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Patrick v. Burget: The Future of Hospital Peer Review Committees in the Antitrust Arena

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PATRICK v. BURGET: THE FUTURE OF HOSPITAL PEER REVIEW COMMITTEES IN THE ANTITRUST ARENA

INTRODUCTION

As health care costs skyrocket[1] and many facilities close,[2] American physicians compete for a decreasing number of hospital staff positions.[3] As a result, physicians may experience difficulty in obtaining hospital staff privileges. Because staff privileges are a necessity for a successful practice, this problem is of concern to physicians.[4] In recent years, many physicians who have had hospital staff privileges either denied or revoked have turned to

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1. *See* Chicago Sun-Times, Nov. 11, 1989, at 7, col. 3. In speaking to the annual Blue Cross and Blue Shield Illinois Health Care Symposium, Former President Gerald R. Ford stated that Americans spent $550 billion on health care in 1988 (11% of the gross national product). If the upward trend in health care costs continues, costs will double by 1995 and triple by the year 2000. *See also* Hamilton, *The Vital Signs Aren't Very Encouraging,* BUS. WK., Jan. 11, 1988, at 104. Health care costs increased at a greater rate than the Consumer Price Index during much of the 1980's. The increase in health care costs has been "gaining momentum since mid-1987." *Id.* Furthermore, Medicare reimbursements to hospitals have not kept up with cost increases. *Id. See also* Note, *Antitrust Implications of Medical Peer Review: Balancing the Competing Interests,* 15 PEPPERDINE L. REV. 111, 111 (1987) (medical costs rising faster than other production costs).

2. *See* Chicago Sun-Times, Aug. 31, 1988, at 7, col. 4. For example, from 1985 to 1988 ten Chicago hospitals were forced to close their doors. *Id.*

3. Cowan, *Medical Staff Legal Issues,* 17 U. TOL. L. REV. 851, 852 (1986). Dr. Cowan discusses the current trends in the hospital environment. He states that the number of physicians from 1960 to 1985 has increased from 141 to 204 per 100,000 people. *Id.* However, there has been a concurrent decline in the number of hospitals. *Id.* Thus, it follows that an increasing number of physicians are competing for a decreasing number of hospital positions. *Id.*

4. *See* Enders, *Federal Antitrust Issues Involved in the Denial of Medical Staff Privileges,* 17 LOY. U. CHI. L.J. 331, 331 (1986) (exclusion from staff may result in substantial economic damage to the physician); Note, *Quality of Care, Staff Privileges, and Antitrust Law,* 64 U. DET. L. REV. 505, 506 (1987) [hereinafter Note, *Quality of Care*] (access to hospital needed for professional survival); Note, *Medical Staff Membership Decisions: Judicial Intervention,* 1985 U. ILL. L. REV. 473, 474 [hereinafter Note, *Medical Staff Decisions*] ("a physician without privileges is almost certain to become a physician without patients") (quoting Goldsmith and Bertolef, *The Present Status of Physician Privileges,* 1981 MED. TRIAL TECH. Q. 121).

The Joint Commission on Accreditation of Hospitals ("JCAH") defines staff privileges as: "[p]ermission to provide medical or other patient carte services in the granting institution, within well-defined limits, based on the individual's professional license and his experience, competence, ability, and judgment." *See* JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS/1985, at 217 (1984) [hereinafter JCAH MANUAL].

the courts for relief by filing various claims.[5] One increasingly common type of suit is based on alleged violations of the federal antitrust law.[6] In most instances, physicians have not prevailed in their antitrust challenges to hospital staff privilege decisions.[7] However, the recent Supreme Court decision in *Patrick v. Burget*[8] suggests this trend might be changing.[9]

In *Patrick v. Burget,* an Oregon physician filed a federal antitrust claim against members of a peer review committee after it revoked his hospital privileges. The defendants claimed they were immune from liability under the state action doctrine. A unanimous Supreme Court reversed a Ninth Circuit decision[10] and held that the state action doctrine did not protect Oregon physicians from federal antitrust liability for their activities on hospital peer review committees.[11] *Patrick* is the first Supreme Court decision to interpret the state action doctrine, an antitrust defense based on state

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5. *See* Groseclose, *Hospital Privilege Cases: Braving the Dismal Swamp,* 26 S.D.L. REV. 1, 3 (1981). Mr. Groseclose discusses various types of suits that a physician may pursue after a hospital has either denied or revoked his staff privileges. The first remedy suggested by Groseclose is judicial review. *See infra* notes 40-59 and accompanying text.

A second type of claim that has been pursued by dissatisfied physicians is one based on contract theory. *See* Groseclose, *supra,* at 25. The contract theory purports that hospital bylaws comprise a contract between the hospital and the physician. *Id.* The person denied initial staff privileges cannot utilize the contract theory since no initial relationship would exist between the physician and the hospital. *Id.* at 25-26. The contract theory may be the only viable remedy in a jurisdiction which prohibits common law judicial review. *Id.* at 28. However, Groseclose states the contract theory should be regarded as a reluctant alternative to common law judicial review. *Id. See also* Lawler v. Eugene Wuesthoff Memorial Hosp. Ass'n, 497 So. 2d 1261, 1263-64 (Fla. Dist. Ct. App. 1986) (physician sufficiently alleged violation of hospital bylaws in termination of staff privileges to bring suit for damages for breach of contract); Margolin v. Morton F. Plant Hosp. Ass'n, 348 So. 2d 57, 57 (Fla. Dist. Ct. App. 1977) (in course of revoking physician's privileges, hospital failed to follow its own bylaws, thus allowing breach of contract action).

A third type of claim that has been advanced by dissatisfied physicians is based on antitrust concepts. Groseclose, *supra,* at 28-29. *See infra* notes 84-106 and accompanying text.

6. Enders, *supra* note 4, at 331 ("in recent years no single health care industry practice has been the target of more antitrust lawsuits than hospital's denial of staff privileges").

7. *See* Goss v. Memorial Hosp. Sys., 789 F.2d 353, 355 (5th Cir. 1986) *(per se* rule not applied to alleged boycott of physician by two hospitals); Smith v. Burns Clinic Medical Center 779 F.2d 1173, 1176 (6th Cir. 1985) (physicians failed to establish prima facie case of monopolization or intent to monopolize); Capili v. Shott, 620 F.2d 438, 439 (4th Cir. 1980) (exclusive contract between anesthesia group and hospital did not substantially effect interstate commerce). *See also* Bierig, *Peer Review After* Patrick, 21 J. HEALTH & HOSP. L. 135 (June 1988) (likelihood of physicians prevailing in antitrust claims is remote due to costs of litigation and Health Care Quality Improvement Act). *But see* Tambone v. Memorial Hosp. for McHenry County, 825 F.2d 1132, 1135 (7th Cir. 1987) (peer review committee not immune from federal liability under state action doctrine absent active state supervision).

8. 486 U.S. 94 (1988).

9. N.Y. Times, May 17, 1988, at A1, col. 5. Kirk Johnson, general counsel of the American Medical Association, stated that in *Patrick* the Court had allowed "the atom bomb of antitrust laws" to be used against peer review panels. *Id.* at D24, col. 4.

10. 800 F.2d 1498 (9th Cir. 1986).

11. 486 U.S. at 105.

immunity from federal antitrust laws,[12] in the hospital peer review context.

Effective peer review is paramount for quality health care.[13] At first glance, the Court's decision may appear to discourage physicians from participating on peer review committees for fear of antitrust liability.[14] However, the decision may have the opposite effect. By its careful analysis of the state action doctrine in the peer review setting, the Court has guided state legislatures and lower courts on how to immunize good faith peer review from antitrust liability.[15]

This Note will discuss peer review liability for antitrust violations, with an emphasis on the state action doctrine defense. In the background section, the Note will review physician staff privileges and the function of peer review committees. In addition, the background section will review judicial review of peer review decisions, and discuss possible defenses to antitrust actions. In that context, the background will discuss state and federal immunity statutes, briefly exploring the Health Care Quality Improvement Act of 1986[16] as a valuable mechanism for immunizing good faith peer review. The main thrust of the background will involve a review of the state action doctrine cases which lead to *Patrick*. Next, this Note will discuss the *Patrick* Court's interpretation of the state action doctrine as a possible defense of peer review committees against antitrust actions. In the analysis, the Note will examine the Court's holding that the state action doctrine does not provide immunity to peer review committees. Finally, the impact section will focus on the actual effect of *Patrick* as the lower courts continue to deal with antitrust attacks on peer review committees.

I. BACKGROUND

A. *Nature and Importance of Staff Privileges*

A brief discussion of hospital staff privileges is necessary to explain their importance to a physician. Hospitals and physicians have an interdependent

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12. *See infra* notes 121-59 and accompanying text.

13. The *Patrick* Court acknowledged the defendants' public policy argument that effective peer review is essential to quality health care. 486 U.S. at 105. *See also* Note, *Quality of Care, supra* note 4, at 524 (antitrust liability may have chilling effect on quality medical care).

14. *See, e.g., Policing Doctor,* TIME, May 30, 1988, at 54; Ross, *Peer Review in Texas—A Survey of Medical Staffs,* 83 TEX. MED. 91, 92 (Mar. 1987). A recent survey of members of the Texas Medical Association revealed that fifty-one percent of physicians were somewhat reluctant to participate in peer review because of the threat of legal liability. *Id. But see* Holthaus, *Peer Review After* Patrick *Case is Alive and Well,* HOSPITALS, Oct. 20, 1988, at 34 (discussion of several cases handed down after *Patrick* which extended protection from antitrust liability to physicians engaged in peer review).

15. *See* N.Y. Times, May 17, 1988, at D24, col. 4. Kirk Johnson, general counsel of the American Medical Association, suggested that state hospital licensing laws be amended to conform with the *Patrick* decision. *Id. See also* Bierig, *supra* note 7, at 135 (risks of antitrust liability for good faith peer review are not substantial).

16. 42 U.S.C. §§ 11101-11152 (Supp. V 1987).

relationship.[17] Hospital staff privileges are an economic necessity to physicians for a number of reasons.[18] One reason is that physicians need a hospital in which to admit patients either for treatment or diagnostic purposes.[19] In addition, not only does a denial or revocation of privileges have an immediate economic impact,[20] it may affect the physician's future earning potential.[21] Finally, staff privileges provide the physician with a mechanism for obtaining referrals in order to expand their patient base.[22] For these reasons, most physicians depend on staff privileges for a successful medical practice.

Similarly, hospitals need physicians to operate and attract patients. Due to new trends in health care,[23] hospitals have become big businesses.[24] A physician with a respected reputation in some specialty area brings both patients and revenue into a hospital.[25] Today, hospital staffing decisions are based not only on physician competence,[26] but also on the realities of the

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17. *See* Miles & Philp, *Hospital Caught in the Antitrust Net: An Overview,* 24 DUQ. L. REV. 489 (1985). The authors describe a hospital as having a tripartite organizational structure. *Id.* at 500. The first entity is the board of trustees or board of directors which is comprised of business persons or community leaders. The overall responsibility of the hospital rests with this governing board. The second entity within the hospital organizational structure is the hospital administration, headed by the hospital president. The administration is responsible for the everyday operation of the hospital and reports to the governing board. *Id.* at 501. Finally, there is the medical staff which is responsible for the quality of medical services at the hospital. *Id. See also* Spivey, *The Relation Between Hospital Management and Medical Staff Under a Prospective-Payment System,* 310 NEW ENG. J. MED. 984 (1984) (discussion of changing relationship between hospital administration and medical staff under Medicare prospective-payment system).

18. *See* sources cited *supra* note 4.

19. *See* Note, *Quality of Care, supra* note 4, at 506 (access to therapeutic and diagnostic equipment vital for professional survival).

20. *See* sources cited *supra* note 4.

21. *See* Note, *Medical Staff Decisions, supra* note 4, at 474.

22. *Id.* (staff privileges important in establishing patient referral networks).

23. Cowan, *supra* note 3, at 851-55. Dr. Cowan provides an excellent analysis of the major trends affecting the delivery of health care in the United States. These trends include: (1) an increase in the number of physicians but a decrease in the number of available hospital staff positions; (2) aggressive cost containment policies; (3) the rise of nonphysician practitioners such as midwifes, psychologists, podiatrists, etc.; (4) the development of alternative health care delivery systems; (5) technological advances; (6) an aging population with the concurrent rise in geriatric medicine; and (7) increasing consumer awareness of patients. *Id.*

24. Health care is a $500 billion industry. For the year ending August 31, 1987, hospital earnings rose 2.8% to $8 billion. *See* Hamilton, *supra* note 1, at 104.

25. *See Hospitals Pursue New Superstars: Famous Physicians,* HOSPITALS, Nov. 20, 1986, at 78. One big advantage of having a superstar physician on staff is that they fill hospital beds. For example, Christiaan Barnard, heart transplant pioneer, has helped the Baptist Medical Center of Oklahoma obtain referrals. *Id. See also* Millenson, *Hospitals Woo Doctors to Win Their Patients,* Chicago Tribune, Feb. 12, 1989, § 7 (Business) at 1, col. 5 (discusses methods by which hospitals recruit prominent physicians).

26. In addition to the obvious concern for physician competence, these decisions also have legal significance for hospital governing boards. *See* Nodzenski, *Medical Staff Decisions in Private Hospitals: The Role of Due Process,* 18 LOY. U. CHI. L.J. 951 (1987). Hospitals may be held liable for the actions of their staff physicians. *See* Darling v. Charleston Community

changing health care market.[27]

B. *Staff Privileges and Peer Review*

The general mechanism by which many hospitals grant initial staff privileges is outlined by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO").[28] According to the JCAHO, professional criteria that hospitals may consider when granting initial staff privileges to a physician include current licensure, previous experience, competency, and health status.[29] Hospitals may consider their own needs, as well.[30] The JCAHO also provides standards for the renewal of existing privileges for physicians who are currently on staff.[31] Reappointment is based on peer recommendations,[32] departmental and/or major clinical service recommendations,[33] and other significant factors.[34]

The JCAHO manual states that one of the factors considered in the reappointment to the hospital staff or the renewal of clinical privileges is

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Memorial Hosp., 33 Ill. 2d 326, 211 N.E.2d 253 (1965). *See also* Trail & Kelley-Claybrook, *Hospital Liability and the Staff Privileges Dilemma,* 37 BAYLOR L. REV. 315, 339 (1985) (discussing hospitals' direct corporate liability for staff physicians).

27. *See* Cowan, *supra* note 3, at 851-55 (discussing general considerations with regard to credentialing).

28. JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS, ACCREDITATION MANUAL FOR HOSPITALS (1989) [hereinafter "JCAHO MANUAL"]. The JCAHO was originally named "The Joint Commission on Accreditation of Hospitals" or "JCAH," but in 1987 that name was changed to reflect the commitment to quality care in all major health care settings. The JCAHO is a voluntary agency that establishes standards for hospitals. If a hospital conforms to all JCAHO guidelines, it receives accreditation. *Id.* at xvii. *See also* Cowan, *supra* note 3, at 857 (discussing 1986 JCAH revisions).

29. JCAHO MANUAL, *supra* note 28, MS.1.2.3.1.2.2, at 102. JCAHO defines clinical privileges as "[p]ermission to provide medical or other patient care services in the granting institution, within well-defined limits, based on the individual's professional license and his experience, competence, ability, and judgment." *Id.* at 101. "Appointment to the medical staff is made through a hospital specific mechanism that is approved and implemented by the medical staff and the governing body, fully documented in the medical staff bylaws, rules and regulations, and policies, as described to each applicant." *Id.* MS 1.2 - MS 1.2.3, at 101-02. Professional criteria that an applicant must meet are specified in the medical staff bylaws. *Id.* MS 1.2.3.1.2, at 101-02. The criteria, which include evidence of current competence, and health status, are applied uniformly to all applicants. *Id.* MS 1.2.3.1.2.2, at 102.

30. *Id.* at 110. Decisions to accept applicants may also be influenced by other criteria, such as: "1) the ability of the hospital to provide adequate facilities and supportive services for the applicant and his patients; 2) patient care needs for additional staff members with the applicant's skill and training; 3) current evidence of adequate professional liability insurance; and 4) the geographic location of the applicant." Id. MS 1.2.3.1.2.3.1-1.2.3.1.2.3.4, at 102.

31. *Id.* MS 5, at 115.

32. *Id.* MS 5.4, at 116 (peer recommendations are part of the evaluation process for reappointment to the medical staff).

33. *Id.* MS 5.5, at 115.

34. *Id.* MS 5.3, at 115-16 (factors include "current licensure, health status, professional performance, judgment and clinical/technical skills, as indicated by the results of the quality assurance activities and other reasonable indicators of continuing qualification").

peer review recommendations.[35] Peer review committees are composed of health care professionals.[36] The committees may be required by state statute[37] and hospital bylaws.[38]

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35. *Id.* MS 5.4, at 116.

36. D. SUBER, PEER REVIEW: A LEGAL UPDATE 3 (1981). *See also* Borsody & Tiano, *Peer Review and the Antitrust Laws: An Analysis and a Proposal,* 26 ST. LOUIS U.L.J. 511 (1982). Peer review may be voluntary or mandatory in nature. Voluntary peer review is conducted by a group of health professionals either for self-regulation purposes, or at the request of an insurer or patient to examine the quality, necessity, or reasonableness of the price of the services received. *Id.* at 511. On the other hand, mandatory peer review is required when professional health care services are paid for by public funds such as under the federal Medicare program. *Id. See* Comment, *Physician Heal Thyself: Because the Cure, the Health Care Quality Improvement Act, May Be Worse Than the Disease,* 37 CATH. U.L. REV. 1073 (1988). A physician is accountable to more than just the state licensure board. He is also accountable to peer review groups. *Id.* at 1081. In the hospital setting, a peer review group grants staff privileges as well as monitors a physician's performance. If a physician fails to meet the requisite standard of care or fails to comply with hospital regulations, the peer review group may investigate and discipline the physician. *Id.*

37. *E.g.,* IND. CODE ANN. § 16-10-1-6.5(c) (Burns 1986) states:

> The medical staff of a hospital shall be an organized group which shall be responsible to the governing board for the clinical and scientific work of the hospital, advice regarding professional matters and policies to the governing board, and shall have the responsibility of reviewing the professional practices in the hospital for the purpose of reducing morbidity and mortality, and for the improvement of the care of patients in the hospital. This review shall include, but shall not be limited to, the quality and necessity of the care provided patients and the preventability of complications and deaths occurring in the hospital.

Id.

38. *E.g.,* CHILDREN'S MEMORIAL HOSPITAL, CHICAGO, ILLINOIS, MEDICAL STAFF BYLAWS (1989). Peer review at Children's Memorial Hospital is conducted according to the following process, as outlined in the medical staff bylaws. After a written complaint has been filed against a staff member, the Chief-of-Staff, the appropriate Department Head, and the Staff Member try to agree on a course of action. *Id.* at 19. If these individuals fail to agree on a course of action, the Medical Board shall nominate and elect an *Ad Hoc* Investigative Committee of five members. *Id.* article VI, 6.8, at 19-20. The *Ad Hoc* Investigative Committee conducts an informal investigation of the allegations in the complaint and submits a written report to the Medical Board within thirty days. The report recommends to the medical board one of the following actions:

> (1) not to take any corrective action and terminate the proceedings against the Staff Member;
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> (2) take one or more corrective actions against the Staff Member including: a) a warning, letter of admonition, or letter of reprimand, b) probation or requirements of individual consultation, c) reduction, restriction, suspension, or revocation of clinical privileges, d) reduction of staff category or limitation of any staff prerogatives directly relating to the Staff Members delivery of patient care, e) suspension, reduction, or revocation of any or all of the Staff Member's clinical privileges, f) suspension or revocation of staff membership;
>
> (3) approve a Voluntary Settlement Agreement with the Staff Member.

Id. article VI, 6.10-6.12, at 20-22. The Medical Board then decides on corrective action. The Staff Member is afforded a hearing based upon the Board's decision. *Id.* article VII, 7.1-7.86, at 23-30 (discussing formal hearing procedures).

The goal of a hospital peer review committee is to monitor the quality and the necessity of medical services rendered by a staff physician.[39]

C. *Staff Privileges and Judicial Review*

A physician who has had his staff privileges initially denied or later revoked by a hospital may turn to the courts for relief.[40] Initially at common law, whether a physician was entitled to judicial review of a hospital's unfavorable decision regarding staff privileges depended largely upon whether the hospital was public or private.[41] That rule remains essentially the same; thus, medical staffing decisions of public hospitals are subject to judicial review, while private hospital decisions generally are not.

1. *Judicial Review of Public Hospital Decisions*

Physicians' claims against public hospitals are usually based on the due process clauses of the fifth or fourteenth amendments.[42] Like any other government entity, a public hospital must provide constitutional due process before depriving a person of constitutionally protected rights.[43] To that end, a physician who has been denied staff privileges should be given the reason for his refusal.[44] In its analysis of a claim, a court will determine if a physician has suffered a substantial denial of liberty or property at the hands of the public hospital without any due process safeguards.[45]

2. *Judicial Review of Private Hospital Decisions*

a. Majority rule: private hospital decisions are not subject to judicial review

A majority of jurisdictions do not subject private hospital decisions to judicial review.[46] Because a private hospital is not a government entity it cannot engage in state action, thus it is generally not bound by the constitutional due process requirements of the fifth or fourteenth amendments.[47]

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39. D. SUBER, *supra* note 36, at 3.

40. *See supra* note 5.

41. *See* Hollowell, *Decisions About Hospital Staff Privileges: A Case for Judicial Deference,* 11 LAW, MED. & HEALTH CARE 118, 118 (1983) (public hospitals must comply with due process while private hospitals are generally immune).

42. *Id.*

43. *Id.*

44. *Id.* at 120 (minimal due process requires an opportunity to be heard by the decision-making body and a fair and unbiased decisionmaking tribunal).

45. *Id.* at 119-20.

46. *See* Nodzenski, *supra* note 26, at 953 (majority of jurisdictions do not review private staffing decisions); Southwick, *Hospital Medical Staff Privileges,* 18 DE PAUL L. REV. 655, 664-69 (1969) (private hospitals have discretion in staffing).

47. *See* Hollowell, *supra* note 41, at 118.

This viewpoint is shared by the vast majority of jurisdictions.[48] However, a minority view subjects private staffing decisions to judicial review based on a fiduciary theory.[49]

b. Minority view: private hospitals may be liable on a fiduciary theory

The minority view was first articulated by the New Jersey Supreme Court in *Greisman v. Newcomb Hospital.*[50] In that case, an osteopathic physician filed an application for staff privileges at Newcomb Hospital, a private institution. The hospital refused to review the application because hospital bylaws required an applicant to be a graduate of a school approved by the American Medical Association and to be a member of the County Medical Society.[51] The New Jersey Supreme Court held that the plaintiff physician had a right to have his application evaluated on its own merits despite the bylaw requirement.[52] The court based its reasoning on the fiduciary relationship between the public and a private hospital. The court noted that hospitals operate for the "benefit of the public, and that their existence is for the purpose of faithfully furnishing facilities to the members of the

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48. *See* Note, *Michigan Court Joins Majority in Denying Judicial Review of Staffing Decisions of Private Hospitals,* 6 AM. J. TRIAL ADVOC. 339, 340 (1982) (breakdown of jurisdictions following the majority and minority approaches of judicial review of private hospitals). For examples of case law holding private staffing decisions not subject to judicial review, see Natale v. Sisters of Mercy of Council Bluffs, 243 Iowa 582, 596-97, 52 N.W.2d 701, 709 (1952) (private hospital may exclude a physician from hospital staff); Clark v. Physicians & Surgeons Hosp. Inc., 121 So. 2d 752, 754 (La. Ct. App. 1960) (private hospital had right to exclude physicians from staff); Ponca City Hosp., Inc. v. Murphree, 545 P.2d 738, 742 (Okla. 1976) (absent showing of causal relationship between the state's activity and activity causing injury or claim of discrimination because of race, sex or age, court will not review hospital staffing decision where building of privately owned hospital financed with federal funds); Hagan v. Osteopathic Gen. Hosp., 102 R.I. 717, 726-27, 232 A.2d 596, 602 (1967) (osteopathic physician not denied equal protection or due process when refused staff privileges); Nashville Memorial Hosp., Inc., v. Binkley, 534 S.W.2d 318, 321 (Tenn. 1976) (receipt of federal funds does not deprive private hospital of authority in staffing decisions).

49. *See* Woodard v. Porter Hosp. Inc., 125 Vt. 419, 217 A.2d 37 (1966) (equitable relief available to physician who was unreasonably, arbitrarily, or discriminately excluded from hospital staff). *See also* Reiswig v. St. Joseph's Hosp. & Medical Center, 130 Ariz. 164, 168, 634 P.2d 976, 980 (1981) (hospital regulation requiring a 48-month residency before a physician may enter a training program subject to judicial review of question whether regulation was arbitrary and capricious interference with ability to pursue occupation).

The duties of a private hospital are regulated by its bylaws, constitution, and charter. *Woodard,* 125 Vt. at 122, 217 A.2d at 39. Private hospitals have a broad range of discretion in determining their policies. *Id.* at 123, 217 A.2d at 40. Consequently, those policies will not be subject to judicial review unless they are arbitrary, capricious, or discriminatory. *Id.* The court's power to intervene is derived from its fiduciary powers to benefit the public good. *Id.*

50. 40 N.J. 389, 192 A.2d 817 (1963).

51. *Id.* at 392, 192 A.2d at 819.

52. *Id.* at 401, 192 A.2d at 824.

medical profession in aid of their service to the public."[53] The court also acknowledged that the hospital received a large part of its funds from public sources and, due to its isolated location, had monopoly power.[54]

The *Greisman* view remains in the minority, however. Another example of limited judicial review in the peer review setting has recently been vacated. In *Bolt v. Halifax Hospital Medical Center,*[55] a physician received judicial review of his rejection from three hospitals in Florida. Florida courts construe hospital bylaws as a contract between the physician and the hospital,[56] thus a physician has a cause of action for injunctive relief if a hospital revokes his privileges in violation of hospital bylaws.[57] In such a case, typically the courts review staff privilege decisions to determine if termination was based on fair procedures, valid criteria, and sufficient evidence.[58] The courts do not, however, review the merits.[59] Such limited judicial review of peer review decisions is a middle ground between active judicial review and none at all.

Not all jurisdictions fall clearly in one category or the other. Some have yet to take a stand. The next section will review judicial review of private hospital decisions in Oregon, where the cause of action in *Patrick v. Burget* arose.

c. Judicial review in Oregon

Oregon courts have failed to decide whether to subject private hospital decisions to judicial review. The next two cases demonstrate this reluctance.

1. Huffaker v. Bailey.[60]—In *Huffaker,* a physician was denied initial staff privileges by a private hospital because of an incomplete application. The application failed to document that the physician could work well with others. The Oregon Supreme Court advocated judicial restraint, and therefore did not decide whether private hospitals were subject to judicial review. Instead, the court merely assumed for the circumstances of this case that the decisions would be so subject.[61] Specifically, the court held that the plaintiff would not

53. *Id.* at 403-04, 192 A.2d at 825. The court explained that hospital officials are vested with managing discretion to elevate hospital and medical care standards. *Id.* If a decision to deny staff privileges is unrelated to sound hospital standards or not in furtherance of the common good, the court would be remiss if it did not intervene. *Id.*

54. *Id.* at 396, 192 A.2d at 821. The monopoly was explained as follows. The hospital was the only hospital in the area. *Id.* at 398, 192 A.2d at 824. Because all doctors need hospital facilities, all area doctors wanted to be on staff at Newcomb and all area patients sought needed treatment at Newcomb. *Id.* Consequently, the hospital's discretion in choosing medical personnel was tied to questions of public good. *Id.*

55. 851 F.2d 1273 (11th Cir. 1988), *vacated,* 874 F.2d 755 (11th Cir. 1989) (en banc).

56. *Bolt,* 851 F.2d 1273, 1283 (1988).

57. *Id.*

58. *Id.* at 1283.

59. *Bolt,* 874 F.2d 755 (1989).

60. 273 Or. 273, 540 P.2d 1398 (1975).

61. *Id.* at 275, 540 P.2d at 1399. The court stated, "[i]n view of our conclusion that petitioner cannot prevail even assuming the case is properly before us, we find it unnecessary to decide these interesting questions. . . . Therefore, we assume, but do not decide, that the hospital's decisions are subject to review by mandamus." *Id.*

prevail on the merits even if properly before the court and stated that it was unnecessary to decide the issue of judicial review.[62] According to the Court, "[a]s long as the denial was made in good faith and supported by an adequate factual basis, we are not disposed to invalidate it."[63]

2. Straube v. Emanuel Lutheran Charity Bd.[64]—In *Straube,* the court, like the *Huffaker* court, declined to decide the judicial review issue. In *Straube,* a radiologist brought suit against a private hospital for wrongful suspension of his staff privileges.[65] The Supreme Court of Oregon held that the inability to work with others insofar as it jeopardizes patient care is a good reason to terminate staff privileges.[66] In addressing the issue of the availability of judicial review, the Oregon Supreme Court stated, "[t]his court has never decided whether there is such a duty in Oregon, and it is unnecessary to do so in this case."[67] Thus far, no court in Oregon as decided whether judicial review is available for plaintiffs who wish the merits of their cause considered.

3. *Immunity Statutes*

Physicians whose staff privileges have been revoked or denied through the actions of a peer review committee have sued individual committee members.[68] All fifty states[69] and Congress[70] have enacted legislation that provides

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62. *Id.*

63. *Id.* at 280-81, 540 P.2d at 1401.

64. 287 Or. 375, 600 P.2d 381 (1979).

65. *Id.*

66. *Id.* at 384, 600 P.2d at 387.

67. *Id.* at 380, 600 P.2d at 384.

68. *See* D. SUBER, *supra* note 36, at 3.

69. *See* ALA. CODE § 34-24-58 (1975); ALASKA STAT. § 18.23.020 (1986); ARIZ. REV. STAT. ANN. §§ 36-445.01-02 (1986); ARK. STAT. ANN. § 20-9-502 (1987); CAL. CIV. CODE § 43.7 (West 1982); COLO. REV. STAT. § 12-43.5-101 (1985); CONN. GEN. STAT. ANN. § 38-19a (West 1987); DEL. CODE ANN. tit. 24, § 1768 (1987); FLA. STAT. ANN. § 768.40 (West 1986); GA. CODE ANN. § 88-3202 (Harrison 1986); HAW. REV. STAT. § 663-1.7 (1989); IDAHO CODE § 39-1392c (1985); ILL. REV. STAT. ch. 111, para. 4400-5 (1987); IND. CODE ANN. § 34-4-12.6-3 (Burns 1986); IOWA CODE ANN. § 147.135 (West Supp. 1988); KAN. STAT. ANN. § 65-442 (1985); KY. REV. STAT. ANN. § 311.377 (Michie/Bobbs-Merrill 1983 & Supp. 1988); LA. REV. STAT. ANN. § 44.7 (West 1982); ME. REV. STAT. ANN. tit. 32, § 3293 (1988 & Supp. 1988-1989); MD. HEALTH OCC. CODE ANN. § 14-603 (1986); MASS. GEN. LAWS ANN. ch. 231, § 85N (West 1985 & Supp. 1988); MICH. COMP. LAWS ANN. § 331.531 (West 1980); MINN. STAT. ANN. § 145.63 (West Supp. 1988-89); MISS. CODE ANN. § 41-63-5 (1972 & Supp. 1988); MO. ANN. STAT. § 537.035 (Vernon 1988); MONT. CODE ANN. § 37-2-201 (1987); NEB. REV. STAT. § 71-147.01 (1986); NEV. REV. STAT. § 630.364 (1985); N.H. REV. STAT. ANN. § 507-8-c (1983); N.J. STAT. ANN. § 2A:84A-22.10 (West Supp. 1988-89); N.M. STAT. ANN. § 41-9-4 (1986); N.Y. EDUC. LAW § 6527 (McKinney 1985 & Supp. 1989); N.C. GEN. STAT. § 131E-95 (1988); N.D. CENT. CODE § 23-01-02.1 (1978 & Supp. 1987); OHIO REV. CODE ANN. § 2305.25 (Anderson 1981 & Supp. 1987); OKLA. STAT. ANN. tit. 76, §§ 24-28 (West Supp. 1988-89); OR. REV. STAT. § 41.675 (1987); PA. STAT. ANN. tit. 63, § 425.3 (Purdon Supp. 1988); R.I. GEN. LAWS § 5-37.3-7 (1987); S.C. CODE ANN. § 40-71-10 (Law. Co-op. 1986); S.D. CODIFIED LAWS ANN. § 36-4-25 (1986); TENN. CODE ANN. § 63-6-219 (1986 & Supp. 1988); TEX. REV. CIV. STAT. ANN. art.

immunity for physicians serving on peer review committees.[71] Immunity statutes for peer review activities vary in content and in the scope of protection that is offered. In addition to state immunity statutes, the recently enacted Health Care Quality Improvement Act of 1986 provides a degree of immunity for peer review participants.[72]

a. State immunity statutes

Generally, most state immunity statutes provide legal immunity for peer review committee members who act in good faith and without malice in conducting their investigations.[73] Some statutes offer immunity to nonphysician members of a peer review committee. For example, the Illinois immunity statute provides immunity to any person serving on the committee or providing service to the committee.[74] To qualify for immunity, most statutes require that a member act in good faith, without malice, or with reasonableness.[75] The Illinois statute protects all peer review activities which do not involve willful and wanton misconduct.[76]

b. The Health Care Quality Improvement Act of 1986

The Health Care Quality Improvement Act of 1986[77] ("Act") is the applicable federal immunity statute. The Act has two features. First, it grants immunity to physicians serving on peer review committees as long as they conform to the requirements of the Act.[78] Second, the Act requires the

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4495B, § 5.06 (Vernon Supp. 1988-1989); UTAH CODE ANN. § 58-12-25 (1986 & Supp. 1988); VT. STAT. ANN. tit. 26, § 1441 (Supp. 1988-1989); VA. CODE ANN. § 8.01-581.16 (1984 & Supp. 1988); WASH. REV. CODE ANN. § 4.24.240 (1988); W. VA. CODE § 30-3C-2 (1986); WIS. STAT. ANN. § 146.37 (West Supp. 1988); WYO. STAT. § 35-2-603 (1988).

70. *See* 42 U.S.C. §§ 11101-11151 (Supp. V 1987).

71. *See* D. SUBER, *supra* note 36, at 7.

72. 42 U.S.C. §§ 11101-11152 (Supp. V 1987).

73. *See, e.g.*, ILL. REV. STAT. ch. 111, para. 4400-5 (1987) ("any person serving on such committee . . . shall not be liable for civil damages as a result of their acts, omissions, decisions, or any other conduct in connection with their duties on such committees, except those involving wilful or wanton misconduct").

74. *Id.*

75. *See, e.g.*, HAW. REV. STAT. § 663-1.7(b) (1989) ("There shall be no civil liability for any member of a peer review committee . . . provided that . . . [t]he member . . . acted without malice; and . . . the member was authorized to perform in the manner in which the member did."). *See also* R.I. GEN. LAWS § 5-37.3-7(f) (1987) ("no member of a medical peer review committee . . . shall be criminally or civilly liable for the performance of any duty . . . provided that such action is without malice and is based upon a reasonable belief that the action is warranted").

76. ILL. REV. STAT. ch. 111, para. 4400-5 (1987).

77. 42 U.S.C. §§ 11101-11152 (Supp. V 1987).

78. The Health Care Quality Improvement Act of 1986 states that Congress finds the following:

> (1) The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater

reporting of any information on malpractice payments or disciplinary actions to the Secretary of Health and Human Services or to any entity designated by the Secretary.[79]

Congress enacted the Act to address the increasing occurrences of malpractice and to improve the quality of medical care nationwide.[80] In addition, it intended to restrict the movement of incompetent physicians from state to state.[81] To this end, Congress hoped to remedy these problems through effective peer review.[82] By providing immunity for good faith peer review actions, Congress intended to encourage professional participation in such committees.[83]

D. Antitrust Issues in Peer Review

In addition to suing individual committee members, physicians have challenged peer review decisions by filing antitrust actions against review com-

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efforts than those that can be undertaken by any individual state.

(2) There is a national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance.

(3) This nationwide problem can be remedied through effective professional peer review.

(4) The threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review.

(5) There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.

42 U.S.C. § 11101 (Supp. V 1987).

Immunity for peer review committee members will attach only if there is compliance with the Act. *See* 42 U.S.C. § 11112 (Supp. V 1987). Section 11112(a) provides that for purposes of the protection set forth in section 11111(a) of title 42, a professional review action must be taken:

(1) in the reasonable belief that the action was in the furtherance of quality health care,

(2) after a reasonable effort to obtain the facts of the matter,

(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures are as fair to the physician under the circumstances, and

(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirements of paragraph (3). A professional review action shall be presumed to have met the preceding standards necessary or the protection set out in section 11111(a) of this title unless the presumption is rebutted by a pre-ponderance of the evidence.

42 U.S.C. § 11112 (Supp. V 1987). *See also* George, *The Health Care Quality Improvement Act of 1986,* 84 N.J. MED. 401 (June 1987); Iglehart, *Congress Moves to Bolster Peer Review: The Health Care Quality Improvement Act of 1986,* 316 NEW ENG. J. MED. 960 (Apr. 9, 1987); Note, *Physician Staff Privilege Cases: Antitrust Liability and the Health Care Quality Improvement Act,* 29 WM. & MARY L. REV. 609 (1988).

79. *See* George, *supra* note 78, at 401.

80. 42 U.S.C. § 11101(a)(1) (Supp. V 1987).

81. *Id.* § 11101(a)(2).

82. *Id.* § 11101(a)(3).

83. *Id.* § 11101(a)(4).

mittees and hospitals.[84] Generally, plaintiffs file these actions under section 1 of the Sherman Act.[85] The federal antitrust statute prohibits contracts and

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84. *E.g.*, Tambone v. Memorial Hosp. for McHenry County, Inc., 825 F.2d 1132 (7th Cir. 1987) (peer review committee not immune from antitrust liability under state action doctrine); Sarin v. Samaritan Health Center, 813 F.2d 755 (6th Cir. 1987), *later proceeding*, 176 Mich. App. 790, 440 N.W.2d 80 (physician could not prevail under antitrust law for failure to show de minimis effect on interstate commerce); Goss v. Memorial Hosp. Sys., 789 F.2d 353 (5th Cir. 1986) *(per se* rule not applied to alleged boycott of physician by two hospitals); Cooper v. Forsyth County Hosp. Authority, Inc., 789 F.2d 278 (4th Cir. 1986) (podiatrists unsuccessful in claim of anticompetitive conspiracy against hospital), *cert. denied*, 479 U.S. 972 (1986); Doe v. St. Joseph's Hosp. of Fort Wayne, 788 F.2d 411 (7th Cir. 1986) (physician failed to state claim under antitrust laws); Smith v. Burns Clinic Medical Center, P.C., 779 F.2d 1173 (6th Cir. 1985) (physicians failed to establish a prima facie case of monopolization); Marrese v. Interqual, Inc., 748 F.2d 373 (7th Cir. 1984) (hospital and peer review committee exempt from antitrust liability under the state action doctrine), *cert. denied*, 472 U.S. 1027 (1985); Weiss v. York Hosp., 745 F.2d 786 (3d Cir. 1984) (class action against hospital for denial of staff privileges of osteopaths), *cert. denied*, 470 U.S. 1060 (1985); Crane v. Intermountain Health Care, Inc., 637 F.2d 715 (10th Cir. 1981) (rehearing en banc) (pathologist victorious in antitrust claim against hospital on price fixing and limitation of competition); Quinn v. Kent General Hosp., Inc., 673 F. Supp. 1367 (D. Del. 1987) (residency requirement for staff physicians had substantial effect on interstate commerce); Vuciecevic v. MacNeal Memorial Hosp., 572 F. Supp. 1424 (N.D. Ill. 1983) (physician unsuccessful in antitrust claim under either *per se* rule or rule of reason); Pontius v. Children's Hosp., 552 F. Supp. 1352 (W.D. Pa. 1982) (pediatric cardiothoracic surgeon brought antitrust action for revocation of staff privileges).

The use of the antitrust laws to challenge unfavorable results and obtain judicial review of peer review decisions has increased dramatically. "This trend is based on the destruction of traditional barriers to antitrust suits against health care providers, changes in the character of the health care market, and the limited success physicians have achieved in obtaining judicial review of staff privilege decisions." Trail & Kelley-Claybrook, *supra* note 26, at 354. The fact that the Supreme Court has held such decisions subject to the antitrust laws is consistent with the significant increase in competition that has been caused by the changes in the health care industry. *Id.* These authors discuss the number of changes that the health care industry has witnessed in the last several decades, including reconstruction of the cost reimbursement system, growth of private, for-profit hospitals, and proliferation of HMOs. *Id.* at 353-54.

85. *See* Trail & Kelly-Claybrook, *supra* note 26, at 359. *See, e.g.*, Tambone v. Memorial Hosp. for McHenry County, Inc., 825 F.2d 1132 (7th Cir. 1987).

Plaintiffs challenging peer review decisions may also join their section 1 claim with a monopolization claim under section 2.

> The test for determining whether a defendant has monopolized in violation of section 2 has been articulated as: '(1) the possession of monopoly power in the relevant market and (2) the willful acquisition or maintenance of that power as distinguished from growth or development as a consequence of a superior product, business acumen, or historic accident.'

Weiss v. York Hosp., 745 F.2d 786, 825 (3d Cir. 1984), *cert. denied*, 470 U.S. 1060 (1985) (quoting United States v. Grinnell Corp., 384 U.S. 563, 570-71 (1966)). Definition of the relevant product and geographic markets, proof of defendant's monopoly power, and proof of its willful acquisition are all part of the section 2 analysis. *See id.* at 825-28. Perhaps because of the more complex analysis for monopolization claims, plaintiffs' section 2 claims often fail where their section 1 claims succeed. *Id.* at 817-29. For other examples of cases where section 2 claims have failed, see Bhan v. NME Hosp., Inc., 669 F. Supp. 998 (E.D. Cal. 1987) (nurse anesthetist did not prevail in claim against hospital in absence of evidence of market for anesthesia services or defendant hospital's power in that market); Cooper v. Forsyth County Hosp. Authority,

conspiracies which restrain trade and reduce competition.[86] The Supreme Court has long noted, however, that every commercial agreement, like a peer review decision, restrains trade.[87] Thus, only those agreements which unreasonably restrain trade are held to violate section 1 of the Sherman Act.[88]

Initially, a plaintiff who attempts to bring an antitrust action under the Sherman Act must satisfy a jurisdictional requirement. That is, the plaintiff must show some connection between denial of privileges and interstate commerce.[89] To fulfill the jurisdictional requirements under sections 1 and 2 of the Sherman Act, a plaintiff must allege and prove a substantial effect on interstate commerce.[90] There is a split in the circuits as to exactly what

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Inc., 789 F.2d 278 (4th Cir. 1986) (podiatrists denied privileges failed to offer sufficient evidence of existence of a conspiracy to monopolize the foot care market), *cert. denied,* 479 U.S. 972 (1986); Konik v. Champlain Valley Physicians Hosp. Medical Center, 733 F.2d 1007 (2d Cir.) (anesthesiologist's claim that hospital and corporation attempted and conspired to monopolize anesthesia services rejected), *cert. denied,* 469 U.S. 884 (1984); Pontius v. Children's Hosp., 552 F. Supp. 1352 (W.D. Pa. 1982) (pediatric surgeon's claim rejected where he failed to show any intent on part of hospital or staff to monopolize); Robinson v. Magovern, 521 F. Supp. 842 (W.D. Pa. 1981) (surgeon's claim rejected where evidence did not support allegations that defendant hospital's denial of staff privileges constituted monopolization, attempted monopolization, or conspiracy to monopolize open-heart surgery market), *aff'd,* 688 F.2d 824 (3d Cir.), *cert. denied,* 459 U.S. 971 (1982).

For additional resources on antitrust challenges to staff privilege decisions based on peer review, see Dolan & Ralston, *Hospital Admitting Privileges and the Sherman Act,* 18 HOUS. L. REV. 707 (1981); Drexel, *The Antitrust Implications of the Denial of Staff Privileges,* 36 U. MIAMI L. REV. 207 (1982); Halper, *The Health Care Industry and the Antitrust Law: Collision Course?,* 49 ANTITRUST L.J. 17 (1980); Kissam, Webber, Bigus & Holzgraefe, *Antitrust and Hospital Privileges: Testing the Conventional Wisdoms,* 70 CALIF. L. REV. 595 (1982); Miles & Philp, *supra* note 17, at 489; Note, *The Denial of Open Staff Hospital Privileges: An Antitrust Scrutiny,* 26 ST. LOUIS U.L.J. 751 (1982).

86. "Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal . . . ." 15 U.S.C. § 1 (1982).

87. Northwest Wholesaler Stationers, Inc. v. Pacific Stationery & Printing Co., 472 U.S. 284, 289 (1985) ("[E]very commercial agreement restrains trade."); Chicago Bd. of Trade v. United States, 246 U.S. 231, 238 (1918) ("Every agreement concerning trade, every regulation of trade, restrains. To bind, to restrain, is of their very essence.").

88. *Northwest,* 472 U.S. at 289 ("Whether this action violates section 1 of the Sherman Act depends on whether it is adjudged an *unreasonable* restraint.") (emphasis in original). "The true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition." *Chicago Bd. of Trade,* 246 U.S. at 238.

89. Sections 1 and 2 of the Sherman Act prohibit restraints of trade and monopolizing behavior that affect "trade or commerce among the several states, or with foreign nations." 15 U.S.C. §§ 1, 2 (1982). *See* Kissam, Webber, Bigus & Holzgraefe, *supra* note 85, at 614.

90. Miles & Philp, *supra* note 17, at 505-06. The authors explain the jurisdictional requirement as follows. The plaintiff in any antitrust case brought under sections 1 and 2 of the Sherman Act must allege and prove a substantial effect on interstate commerce. There is a split in the circuits regarding whether the plaintiff must show that the alleged *restraint* affects commerce, or whether a showing that the *general business activities of the defendant* affect interstate commerce is sufficient. *Id.* at 505 (emphasis in original).

a plaintiff must allege. Some courts have held that a physician must allege an effect on interstate commerce resulting from the defendant's general business activities.[91] Other courts have held that a physician must allege an effect on interstate commerce resulting from the hospital's alleged illegal activity.[92]

After the claim passes the jurisdictional test, the federal courts[93] have developed two modes of analyzing the reasonableness of a particular agreement. These approaches are: (1) the *per se* analysis; and, (2) the Rule of Reason analysis.

1. Per se analysis

The *per se* analysis is used only in cases where the challenged business activity is the type which has "proved to be predominantly anticompetitive."[94] Several classes of behavior constitute *per se* violations. One example of a *per se* violation is a concerted refusal to deal or a group boycott.[95] Other examples of *per se* violations are price-fixing agreements and territorial restrictions.[96] Although the *per se* rule may be easier than the Rule of Reason analysis for courts to apply,[97] the Supreme Court has cautioned against

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91. *E.g.*, Robinson v. Magovern, 521 F. Supp. 842 (W.D. Pa. 1981), *aff'd*, 688 F.2d 824 (3d Cir.), *cert. denied*, 459 U.S. 971 (1982).

92. *E.g.*, Doe v. St. Joseph's Hosp., 788 F.2d 411, 417 (7th Cir. 1986).

93. "[F]ederal antitrust claims are within the exclusive jurisdiction of the federal courts." Marrese v. American Academy of Orthopaedic Surgeons, 470 U.S. 373, 375 (1985). *But see* Marrese v. American Academy of Orthopaedic Surgeons, 726 F.2d 1150, 1153 (7th Cir. 1984) (en banc) (dictum) ("[I]t is hard to understand why state courts should be thought less competent to enforce the federal antitrust laws than the federal civil rights laws—which they have jurisdiction concurrently with the federal courts to enforce—particularly when they can adjudicate federal antitrust defenses with preclusive effect."), *rev'd*, 470 U.S. 373 (1985).

94. Northwest Wholesaler Stationers, Inc. v. Pacific Stationary 7 Printing Co., 472 U.S. 284, 289 (1985). "The decision to apply the *per se* rule turns on 'whether the practice facially appears to be one that would always or almost always tend to restrict competition and decrease output . . . .' " *Id.* at 289-90 (citing Broadcast Music, Inc. v. Columbia Broadcasting Sys., Inc., 441 U.S. 1, 19-20 (1979)).

95. *See Northwest*, 472 U.S. at 290. Such activity is "so likely to restrict competition without any offsetting efficiency gains that they should be condemned as *per se* violations of (section) 1 of the Sherman Act." *Id.* Another example of a *per se* violation is an agreement to fix prices. *See* Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332, 351 (1982); Addyston Pipe & Steel Co. v. United States, 85 F. 271 (6th Cir. 1898) (price-fixing held a section 1 violation), *aff'd*, 175 U.S. 211 (1899).

96. *E.g.*, United States v. Topco Assocs., 405 U.S. 596 (1972) (horizontal restraints, defined as an "agreement between competitors at the same level of the market structure to allocate territories in order to minimize competition," are *per se* violations of section 1 of the Sherman Act); United States v. Socony-Vacuum Oil Co., 310 U.S. 150, 223 (1940) (setting forth the *per se* rule against price fixing agreements as "a combination formed for the purpose and with the effect of raising, depressing, fixing, pegging, or stabilizing the price of a commodity in interstate or foreign commerce is illegal *per se*").

97. Under the *per se* rule, agreements which fall into certain categories, such as price-fixing agreements, are *per se* unreasonable and are struck without consideration of purpose, power or effect. United States v. Socony-Vacuum Oil Co., 310 U.S. 150, 223 n.59 (1940).

overzealous use of the *per se* analysis.[98] Thus, courts have generally rejected application of a *per se* analysis to staff privilege decisions.[99] Instead, courts apply the Rule of Reason analysis to such cases.

2. *Rule of Reason analysis*

Under the Rule of Reason analysis, "the factfinder weighs all of the circumstances of a case in deciding whether a restrictive practice should be prohibited as imposing an unreasonable restraint on competition."[100] The considerations relevant to the reasonableness of a staff privilege decision may include the legitimacy of evaluation criteria, notice of such criteria to the plaintiff, and the decision's consistency with other staff privilege decisions.[101] Because a restrictive practice may have both anticompetitive and procompetitive effects, a court will find an antitrust violation only if the anticompetitive effects predominate.[102]

It has been noted that antitrust challenges to staff privilege decisions usually arise in three scenarios.[103] First, a dissatisfied physician may allege that the denial of privileges resulted from a conspiracy between the credentialing committee and the governing body.[104] Second, a dissatisfied physician

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98. *See, e.g.,* Broadcast Music, Inc. v. Columbia Broadcasting Sys., Inc., 441 U.S. 1, 19-20 (1979) *(per se* treatment justified only where purpose and effect of challenged practice are to threaten free market economy); United States v. Topco Assocs., Inc., 405 U.S. 596, 607-08 (1972) ("It is only after considerable experience with certain business relationships that courts classify them as *per se* violations of the Sherman Act.").

99. *See* Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2, 26-29 (1984); Goss v. Memorial Hosp. System, 789 F.2d 353, 354-56 (5th Cir. 1986); Vuciecevic v. MacNeal Memorial Hosp., 572 F. Supp. 1424, 1427-29 (N.D. Ill. 1983); Pontius v. Children's Hosp., 552 F. Supp. 1352, 1367-70 (W.D. Pa. 1982); Robinson v. Magovern, 521 F. Supp 842, 919-25 (W.D. Pa. 1981). *But see* Weiss v. York Hosp., 745 F.2d 786, 818-22 (applying *per se* analysis but noting the discriminatory application of standards and lack of explanation for excluding osteopaths as a group). *See also* Trail & Kelly-Claybrook, *supra* note 26, at 357-58 (unless defendant's anticompetitive purpose is demonstrated, *per se* standard will not be applied to staff privilege decisions).

100. Continental T.V., Inc. v. GTE Sylvania, Inc., 433 U.S. 36, 49 (1977) (footnote omitted).

101. *See* Robinson v. Magovern, 521 F. Supp. 842, 919-25 (W.D. Pa. 1981), *aff'd,* 688 F.2d 824 (3d Cir.), *cert. denied,* 459 U.S. 971 (1982).

102. *See* National Soc'y of Prof. Eng'rs v. United States, 435 U.S. 679, 688-89 (1978). *See also Robinson,* 521 F. Supp. at 919 (hospital staff selection policy not unreasonable because favorable competitive effects of policy outweigh anticompetitive effects).

103. *See* Enders, *supra* note 4, at 332; *See also* Miles & Philp, *supra* note 17, at 498. These authors state that antitrust problems usually arise from the following factual contexts:

> 1) Denial of a physician's initial application for medical staff membership or clinical privileges; 2) Denial of privileges to allied health professionals such as nurse midwives, nurse anesthetists, podiatrists, and chiropractors; 3) Nonrenewal of a practitioner's clinical privileges; 4) Denial of some clinical privileges while granting of others; 5) Suspension, reduction, or termination of privileges; and 6) An exclusive contract between the hospital and a single physician (or single group of physicians) to provide the medical services in question at the hospital.

Id. at 498-99.

104. Enders, *supra* note 4, at 332.

may allege that the hospital medical staff conspired to exclude him from the staff.[105] Finally, when an exclusive arrangement or contract exists between the hospital and a group of specialists, a dissatisfied physician may allege an unlawful arrangement.[106]

E. Possible Defenses to Antitrust Challenges

1. The Supreme Court rejected two rationales

The Supreme Court has rejected two rationales which litigants and commentators have suggested might shield the health care industry from antitrust claims. One proposed rationale for immunity from the antitrust laws is that there should be a "learned professions" exemption for the health industry on the basis that it is noncommercial, or rather, not a "trade or commerce" encompassed by the antitrust laws.[107] However, in *Goldfarb v. Virginia State Bar,*[108] the Court rejected a learned professions exemption when it held that "[t]he nature of an occupation, standing alone, does not provide sanctuary from the Sherman Act."[109] Although *Goldfarb* involved the legal profession, subsequent Supreme Court cases have made it clear that there is no learned professions exemption, at least at the federal level, that shields anticompetitive practices in the medical profession.[110]

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105. *Id.*

106. *Id. See* Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2 (1984).

107. Kissam, Webber, Bigus, & Holzgraefe, *supra* note 85, at 614-15.

108. 421 U.S. 773 (1975).

109. *Id.* at 787. In *Goldfarb,* petitioners could not locate an attorney who would examine the title to a house they were purchasing for less than the amount listed in the minimum fee schedule published by the Fairfax County Bar Association and enforced by the Virginia State Bar. Petitioners filed an antitrust suit claiming that the minimum fee schedule violated section 1 of the Sherman Act. *Id.* at 776-78.

One of the arguments made by the County Bar against the application of the antitrust laws was that Congress never intended to include the learned professions within the scope of the Sherman Act. *Id.* at 786. The Court stressed that it could not "find support for the proposition that Congress intended any such sweeping exclusion." *Id.* at 787. Although the Court acknowledged that professions are different from trades and other businesses, the Court found that the practice of law has a sufficient "business aspect" to be encompassed within the antitrust laws. *Id.* at 787-88. *See generally* Kissam, Webber, Bigus & Holzgraefe, *supra* note 85, at 614. The Court rejected such a "sweeping" exemption for three reasons: (1) the absence of any statutory language or legislative history to support such an exemption; (2) the "heavy presumption" against implicit or judicially recognized exemptions from federal antitrust law; and (3) the "business" or "commercial" aspect of exchanging professional services for money. *Id.*

110. *E.g.,* National Soc'y of Prof. Eng'rs v. United States, 435 U.S. 679, 696 (1978) (professional engineers may not establish an ethical canon which prohibits competitive bidding, and *Goldfarb* should not be read as fashioning a broad exemption under the Rule of Reason for learned professions) (citing Goldfarb v. Virginia State Bar, 421 U.S. 773, 788-89 n.17 (1975)). *See generally* Trail & Kelley-Claybrook, *supra* note 26, at 362 (collecting cases); Kissam, Webber, Bigus & Holzgraefe, *supra* note 85, at 614-16 (gives analysis of case law and concludes that "[i]t is unlikely . . . that federal courts will recognize an antitrust exemption that covers privilege decisions" on the basis of a learned profession or noncommercial exemption).

A second argument for immunizing medical peer review decisions from the antitrust laws is that the activity is inherently local and is outside the realm of the antitrust laws.[111] Therefore, it does not affect interstate commerce. However, this possible exemption, based on the jurisdictional requirements of the Sherman Act, was also rejected by the Supreme Court.[112]

In *Hospital Building Co. v. Trustees of Rex Hospital,*[113] petitioner brought an antitrust action under both sections 1 and 2 of the Sherman Act, alleging that respondents acted in concert to block the relocation and expansion of petitioner's hospital, and that intentional delay tactics were for the purpose of monopolizing "the business of providing compensated medical and surgical services" in the area.[114] The Supreme Court disagreed with the appellate court's conclusion that interstate commerce was not affected.[115] "[T]he fact that an effect on interstate commerce might be termed 'indirect' because the conduct producing it is not 'purposely directed' toward interstate commerce does not lead to a conclusion that the conduct at issue is outside the scope of the Sherman Act."[116] The Court's holding merely stated that conduct may affect interstate commerce and thus satisfy the jurisdictional requirement of the Sherman Act even if it was not "purposely directed" toward interstate commerce.[117] In other words, an indirect effect on interstate commerce may be sufficient.[118] It follows that if the action was not purposefully directed at interstate commerce and in addition did not have even an indirect effect on interstate commerce, the jurisdictional defense may still be valid. Defendants continue to raise this defense.[119]

Clearly, the peer review process utilized by hospitals in making staff privilege decisions often implicates the antitrust laws.[120] In light of the Court's rejection of learned professions or noncommercial grounds for exemption, defendants have turned to the state action doctrine as a possible defense. Because of the increasing importance of the state action doctrine in these cases, the next section will describe the basic aspects of this doctrine.

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111. Section 1 of the Sherman Antitrust Act provides: "Every contract, combination in form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several states, or with foreign nations is declared to be illegal . . . ." 15 U.S.C. § 1 (1980). *See also* Trail & Kelley-Claybrook, *supra* note 26, at 351-52 (observing Supreme Court's rejection of exempting health care industry from antitrust protection).

112. *See* Trail & Kelley-Claybrook, *supra* note 26, at 351-52.

113. 425 U.S. 738 (1976).

114. *Id.* at 740-41.

115. *Id.* at 743-44.

116. *Id.* at 744.

117. *Id.*

118. *Id.*

119. *See* Proger, *Antitrust Developments Affecting the Health Care Sector,* 57 ANTITRUST L.J. 315 (1988).

120. *See supra* notes 84-106 and accompanying text.

2. *The state action doctrine*

The Supreme Court first articulated the state action doctrine in *Parker v. Brown.*[121] In *Parker,* a California raisin producer filed a suit challenging the state's Agricultural Prorate Act, which established a marketing plan for the 1940 raisin crop, as violative of the Sherman Act.[122] The Court stressed that although the same conduct by private parties would clearly violate the Sherman Act,[123] since the action was authorized by the state,[124] the Court must consider whether Congress meant to include the states within the purview of the Sherman Act.[125] After an examination of the statute and its legislative history, the Court concluded that Congress did not intend to include the states when it passed the Sherman Act.[126]

The *Parker* doctrine, therefore, is an implied exemption which allows states to engage in anticompetitive conduct without restraint from the antitrust laws.[127] Essentially, this exemption has its basis in principles of federalism and a recognition of state sovereignty, in that the Court requires specific Congressional action before the states' authority to regulate within

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121. 317 U.S. 341 (1943). Although *Parker* is credited with establishing the state action doctrine, one commentator has noted the roots of the doctrine prior to *Parker. See* Lopatka, *The State of "State Action" Antitrust Immunity: A Progress Report,* 46 LA. L. REV. 941, 947-48 n.17 (1986).

122. *Parker,* 317 U.S. at 344-47. The marketing plan of the Agricultural Prorate Act regulated the pricing and distribution of the raisin crop. The purpose of the Act was "to prevent economic waste" and to "conserve the agricultural wealth of the state." *Id.* at 346.

123. *Id.* at 350.

124. The program "derived its authority and its efficacy from the legislative command of the state and was not intended to operate or become effective without that command." *Id.* at 350.

125. *Id.* at 350-51.

126. *Id.* "We find nothing in the language of the Sherman Act or in its history which suggests that its purpose was to restrain a state or its officers or agents from activities directed by its legislature." *Id.* at 350-51.

For further discussion of the state action doctrine, see Areeda, *Antitrust Immunity for "State Action" After* Lafayette, 95 HARV. L. REV. 435 (1981); Burling, Lee & Quarles, *"State Action" Antitrust Immunity—A Doctrine in Search of a Definition,* 1982 B.Y.U. L. REV. 809; Easterbrook, *Antitrust and the Economics of Federalism,* 26 J.L. & ECON. 23 (1983); Morgan, *Antitrust and State Regulation: Standards of Immunity After* Midcal, 35 ARK. L. REV. 453 (1981); Page, *Antitrust, Federalism, and the Regulatory Process: A Reconstruction and Critique of the State Action Exemption After* Midcal Aluminum, 61 B.U.L. REV. 1099 (1981); Posner, *The Proper Relationship Between State Regulation and the Federal Antitrust Laws,* 49 N.Y.U. L. REV. 693 (1974); Wiley, *A Capture Theory of Antitrust Federalism,* 99 HARV. L. REV. 713 (1986).

127. *See* Kissam, Webber, Bigus & Holzgraefe, *supra* note 85, at 619. As one commentator points out, "[i]t is clear that the Court found an implied exemption from the antitrust laws for actions undertaken by state representatives that can be attributed to the state. Because federal law contains no express exemption from the antitrust laws for state action, any exemption had to be implied." Lopatka, *supra* note 121, at 951.

their own borders can be curtailed.[128] After *Parker,* however, the Court did not address the doctrine again until 1975, when it decided *Goldfarb.*[129] Between 1975 and 1985, the Court issued a multitude of opinions that attempted to further develop and define the doctrine and its reaches.[130]

a. The *Midcal* test

In *California Retail Liquor Dealers Association v. Midcal Aluminum, Inc.,*[131] the Supreme Court articulated a two-pronged test to determine when

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128. *Parker,* 317 U.S. at 350-51: "In a dual system of government in which, under the Constitution, the states are sovereign, save only as Congress may constitutionally subtract from their authority, an unexpressed purpose to nullify a state's control over its officers and agents is not lightly to be attributed to Congress." *Id.* at 351. *See also* Town of Hallie v. City of Eau Claire, 471 U.S. 34, 38 (1985) ("In *Parker,* relying on principles of federalism and state sovereignty, the Court refused to construe the Sherman Act as applying to the anticompetitive conduct of a State acting through its legislature."); Southern Motor Carriers Rate Conference, Inc. v. United States, 471 U.S. 48, 61 (1985) ("The *Parker* doctrine represents an attempt to resolve conflicts that may arise between principles of federalism and the goal of the antitrust laws, unfettered competition in the marketplace."); Hoover v. Ronwin, 466 U.S. 558, 567 (1984) (the basis of *Parker* were "principles of federalism and state sovereignty"); City of Lafayette v. Louisana Power & Light Co., 435 U.S. 389, 412 (1978) (stressing that cities do not receive the same deference as states which is required by federalism); Malina, *Supreme Court Update: State Action Doctrine,* 54 ANTITRUST L.J. 289, 300 (1985) ("The concept was grounded on the fundamentals of our federal system and reflected an historically sound and pragmatic view of the proper scope of state economic regulation which . . . the Congress that enacted the Sherman Act did not intend to disturb."); Recent Developments, *Antitrust Act-State Action Immunity-Bar Examiners' Liability:* Hoover v. Ronwin, 52 TENN. L. REV. 525, 528-30 (1985) (discussion of *Parker* premises and background of law).

129. 421 U.S. 773 (1975).

130. As one commentator noted:

> [B]eginning with *Goldfarb* in 1975, no other antitrust topic has so captured the Court's attention. Virtually every year brought a new opinion adding a new interpretation—or at least a new gloss—on the doctrine announced with what appeared to be characteristic clarity by Chief Justice Stone in *Parker v. Brown* in 1943.

Malina, *supra* note 128, at 299.

Key Supreme Court decisions on the state action doctrine after *Parker* and *Goldfarb* include: Southern Motor Carriers Rate Conference, Inc. v. United States, 471 U.S. 48, 58-59 (1985) (private party can claim immunity under state action doctrine when conduct is state supervised and pursuant to clearly articulated state policy); Town of Hallie v. City of Eau Claire, 471 U.S. 34, 38-39 (1985) (extended state action immunity to municipalities where state authorized action); Hoover v. Ronwin, 466 U.S. 558, 570-73 (1984) (broadened immunity given to state legislatures and supreme courts to include state officials and agencies when there is nominal supervision or guidelines set forth); California Retail Liquor Dealers Ass'n v. Midcal Aluminum Co., 445 U.S. 97, 105 (1980) (Court enunciates for the first time a two part test to determine whether state action doctrine is applicable); New Motor Vehicle Bd. v. Orrin W. Fox Co., 439 U.S. 96, 109 (1978) (Court upheld a California statute which allowed private restraint of trade since the legislature established "a system of regulation, clearly articulated and affirmatively expressed"); Bates v. State Bar of Arizona, 433 U.S. 350, 359-63 (1977) (the "affirmative command of the Arizona Supreme Court" prohibiting attorney advertising was sufficient as a clear articulation of the state's policy); Cantor v. Detroit Edison Co., 428 U.S. 579, 594-96 (1976) (anticompetitive conduct by private parties must be compelled by the state in order to be protected by the state action doctrine).

131. 445 U.S. 97 (1980). In *Midcal,* state wine producers and wholesalers were required by

the state action doctrine would protect anticompetitive conduct. "First, the challenged restraint must be 'one clearly articulated and affirmatively expressed as state policy'; second, the policy must be 'actively supervised' by the State itself."[132] Although neatly articulated, the *Midcal* test nevertheless created confusion because it left several important questions unanswered.[133] These questions included the extent of protection given to state officials and state actors other than the state legislature or state supreme court, the degree to which municipalities could claim protection, and whether compulsion was necessary to protect private parties acting under a state's authority.

The companion cases of *Town of Hallie v. City of Eau Claire*[134] and *Southern Motor Carriers Rate Conference, Inc. v. United States*[135] cleared up many of the ambiguities left after *Midcal* by delineating the standards to be applied in several contexts.[136] Although the Court has emphasized that "[t]he success of an antitrust action should depend upon the nature of the activity challenged, rather than on the identity of the defendant,"[137] its current approach focuses on the parties. Specifically, unless an action is clearly that of the legislature or state supreme court, *Midcal* is applied to varying degrees depending on the identity of the defendant: a state official or agency, a municipality, or regulated private parties.

1. State supreme court, legislature and municipalities.—When the challenged conduct is that of the state supreme court or legislature, the Supreme Court has stated, in *Hoover v. Ronwin,* that *Midcal* need not be applied at

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a California state statute to file fair trade contracts or price schedules in order to sell wine. No wine merchant was allowed to sell wine at any other price than one set by a fair trade contract or effective price schedule. *Id.* at 99. A wholesaler filed an antitrust challenge after having been fined for violation of the statute, seeking an injunction against the wine-selling scheme. *Id.* at 100.

132. *Id.* at 105 (quoting City of Lafayette v. Louisiana Power & Light Co., 435 U.S. 389, 410 (1978)). In applying the *Midcal* test to the wine pricing system established by the California statute, the Court held that the first prong was satisfied. The state had a clearly articulated policy: "California's system for wine pricing plainly constitutes resale price maintenance." *Id.* at 103. However, the pricing scheme failed to satisfy the second prong of active supervision, since the private wine producers, rather than the state, set the prices. *Id.* at 105. No substantial State involvement afforded California Liquor Dealers Association immunity under the state action doctrine. The Court stressed that "[t]he State simply authorizes price setting and enforces the prices established by private parties. The State neither establishes prices nor reviews the reasonableness of the price schedules; nor does it regulate the terms of fair trade contracts." *Id.* at 105-06.

133. *See generally* Lopatka, *supra* note 121, at 995 ("[w]here the Court went wrong in *Midcal* was to confuse the ultimate fact at issue in state action immunity cases with subsidiary facts tending to prove the ultimate fact"); Malina, *supra* note 128, at 299 *(Midcal* left several questions on the applicability of the doctrine unanswered).

134. 471 U.S. 34 (1985).

135. 471 U.S. 48 (1985).

136. Malina, *supra* note 128, at 299-301.

137. *Southern Motor,* 471 U.S. at 58-59.

all; indeed, such is purely state action that is protected under the doctrine.[138] The extent of protection afforded state officials and agencies is less clear. However, commentators argue that when acts are pursuant to clearly articulated policy, *Midcal* should apply only if there is nominal supervision.[139] As to the degree of protection afforded municipalities, under *Hallie* only the first prong of *Midcal* need be satisfied.[140] The Court rejected the need for compulsion by the state to immunize the municipality's action,[141] as well as a need for active supervision,[142] and held that the doctrine applied to the action if it was "pursuant to a clearly expressed state policy."[143]

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138. 466 U.S. 558, 569 (1984) ("Where the conduct at issue is in fact that of the state legislature or supreme court, we need not address the issues of 'clear articulation' and 'active supervision.' ").

139. Lopatka, *supra* note 121, at 1038:

> The "state," for purposes of state *action,* includes at least the legislature and the state supreme court when acting in a legislative capacity. It should and probably does include the governor and the supreme court acting in any constitutionally appropriate capacity. It also includes some state agencies, but the analysis for determining which agencies constitute the state is uncertain. The best interpretation of Supreme Court precedent is that only legitimate state agencies acting within the scope of their authority represent the state.

Id. In *Hoover,* the Court indicated that "the anticompetitive conduct of a nonsovereign state representative" is encompassed by the state action doctrine when the conduct is pursuant to a clearly articulated state policy, yet "the degree to which the state legislature or supreme court supervises its representative is relevant to the inquiry." 466 U.S. 558, 569 (1984).

The *Hoover* decision is credited with expanding the automatic immunity accorded to state legislatures and supreme courts to include subordinates in certain circumstances. *See* Recent Developments, *State Action Immunity, supra* note 128, at 545.

140. 471 U.S. at 45-46. The Court had previously made it clear that municipalities were not afforded the same deference as states and therefore their actions were not automatically shielded from the antitrust laws. City of Lafayette v. Louisiana Power & Light Co., 435 U.S. 389, 412 (1978). "In light of the serious economic dislocation which could result if cities were free to place their own parochial interests above the Nation's economic goals reflected in the antitrust laws . . . we are especially unwilling to presume that Congress intended to exclude anticompetitive municipal action from their [sic] reach." *Id.* at 412-13. Yet the Court recognized that immunity may exist if the actions of the municipality reflect the state policy, since "[m]unicipal corporations are instrumentalities of the State." *Id.* at 413 (quoting Folsom v. Mayor of New Orleans, 109 U.S. 285, 287 (1883)).

In *Hallie,* the Court acknowledged that its previous decisions on the issue of municipality immunity were less than clear. 471 U.S. at 40.

141. 471 U.S. at 45. The Court held that compulsion by the state was useful as an evidentiary matter to support a municipality's assertion that it is acting pursuant to a clearly articulated state policy. However, although useful, such compulsion was unnecessary to satisfy the first prong of *Midcal. Id.* at 45-46.

142. *Id.* at 46. The Court emphasized that "active state supervision serves essentially an evidentiary function: it is one way of ensuring that the actor is engaging in the challenged conduct pursuant to state policy." *Id.* at 46. Because a municipality is an arm of the State there is little danger of it seeking private goals. *Id.* at 45-47. Rather, the main danger acknowledged by the Court is that the municipality "will seek to further purely parochial public interests at the expense of more overriding State goals." *Id.* If state authorization for the action exists, this danger is eliminated, therefore "there is no need to require the State to supervise actively the municipality's execution of what is a properly delegated function." *Id.*

143. *Id.* at 40.

2. *Protection of private parties.*—Perhaps the most significant question left open after *Midcal* was the extent of protection, if any, given to private parties under the state action doctrine, and whether or not state compulsion was necessary for the doctrine to apply.[144] However, in *Southern Motor,*[145] the Court made it clear that the state action doctrine could be extended to protect private parties if both prongs of the *Midcal* test were satisfied.[146] Also, the Court held that the state need not have *compelled* the private party to act before the state action doctrine could be invoked.[147] Rather, the Court stated that compulsion was evidentiary in nature. Therefore, although its existence would certainly facilitate the inquiry as to whether the private parties were engaging in a clearly articulated state policy, compulsion was not necessary.[148]

The Court found it necessary to extend the *Parker* doctrine's protection to private parties in order to increase the options and flexibility of the state governments in implementing regulatory programs.[149] However, because a private party "may be presumed to be acting primarily on his or its own behalf,"[150] both prongs of the *Midcal* test must be satisfied.[151] In order to satisfy the first prong, the private party need only show that the state sovereign (supreme court or legislature) intended to "displace competition in a particular field with a regulatory structure," or that such was the foreseeable result of a regulatory structure.[152] The second prong of active

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144. Malina, *supra* note 128, at 300-01. Earlier cases had suggested that the doctrine was inapplicable to private parties. *See, e.g.,* Cantor v. Detroit Edison Co., 428 U.S. 579, 591 (1976) (in *Parker,* Chief Justice Stone "carefully selected language which plainly limited the Court's holding to official action taken by state officials"); Parker v. Brown, 317 U.S. 341, 352 (1943) (stating, "[T]he Sherman Act . . . must be taken to be a prohibition of individual and not of state action").

145. 471 U.S. 48 (1985).

146. *Id.* at 61.

147. *Id.* at 60-62.

148. *Id.* Although the Court held that compulsion was not necessary for private parties to satisfy the first prong of *Midcal,* the Court stressed its value as an evidentiary tool: "Our holding . . . does not suggest, however, that compulsion is irrelevant. To the contrary, compulsion often is the best evidence that the State has a clearly articulated and affirmatively expressed policy to displace competition." *Id.* at 61-62.

149. *Id.* at 56-57, 61.

150. Town of Hallie v. City of Eau Claire, 471 U.S. 34, 45 (1985).

151. *Southern Motor,* 471 U.S. at 58-59. For an interesting comparison of distinctions between the state, municipalities, and private parties, and how the evidentiary functions of compulsion and supervision serve these differences in light of the *Midcal* test, see *Hallie,* 471 U.S. at 42-46.

152. *Southern Motor,* 471 U.S. at 64. "A private party acting pursuant to an anticompetitive regulatory program need not 'point to a specific, detailed legislative authorization' for its challenged conduct." *Id.* (quoting Lafayette v. Louisiana Power & Light Co., 435 U.S. 389, 415 (1977)).

One commentator explains how the first prong is satisfied:

> The clear state policy requirement is satisfied if the private conduct that constitutes the restraint challenged was the foreseeable result of the state's pronouncements.

supervision must also be met before a private party is accorded protection under the state action doctrine.[153] As one commentator noted, "[a]ctive supervision requires rather vigorous oversight, something akin to traditional public utility regulation."[154] Finally, in terms of the proper authority to express policy and supervise the private parties, agencies and state officials would probably suffice, as long as the clearly articulated policy can somehow be traced to policy articulated by "a constitutional branch of government."[155]

3. State action doctrine as peer review defense.—When peer review results in the termination, limitation, or refusal of hospital staff privileges, the aggrieved doctor will probably have jurisdictional grounds under the Sherman Act to bring an antitrust challenge against the hospital as well as the doctors who participated in the evaluating committee.[156] If the relevant hospital is private,[157] whether or not the peer review committee's decision is protected by the state action doctrine depends on whether there exists a state statutory scheme establishing peer review that satisfies *Midcal*.[158] If no statutory scheme exists, the state action doctrine may still be raised if some other form of state supervision, such as administrative agency review or judicial review, satisfies *Midcal*.[159]

> The state need not explicitly refer to the challenged activity or the anticompetitive effects of that conduct. The state need not compel the activity; a permissive state policy is adequate. Nor does immunity require that the activity be necessary to make the regulatory act work. The best position on the issue is that private conduct challenged as a restraint is protected if the state acted in such a way that the private conduct was a likely consequence.

Lopatka, *supra* note 121, at 1038. *See also* P. AREEDA & H. HOVENKAMP, ANTITRUST LAW ¶ 201.9a, at 83 (1988 Supp.) (the relevant inquiry is whether "the state really wants to displace federal antitrust law and manifests that policy choice through an affirmative and clearly articulated expression").

153. *See Southern Motor,* 471 U.S. at 62; *Hallie,* 471 U.S. at 46 n.10. As Areeda explains, "[b]ecause state creation of unsupervised private power would be clearly inconsistent with the federal antitrust laws . . . state law could not immunize private conduct without providing for its public supervision." P. AREEDA & H. HOVENKAMP, *supra* note 152, ¶ 212.7, at 155.

154. Lopatka, *supra* note 121, at 1038-39.

155. *Id.*

156. At least one commentator has noted that courts dislike such challenges, and strain to dismiss the cases early in litigation, creating "inconsistent and ambiguous analyses." Miles & Philp, *supra* note 17, at 504-05. "[A]ntitrust staff privilege cases . . . are expensive and time consuming; the plaintiff wins infrequently; and the courts appear quite reluctant to second-guess the decisions of hospitals and medical staffs with regard to staffing decisions." *Id.*

157. If the anticompetitive decision is made by a public hospital, *Midcal* probably does not apply. *See generally* Kissam, Webber, Bigus & Holzgraefe, *supra* note 85, at 623-25 (providing a plausible pre-*Hallie* analysis to anticompetitive decisions made by public hospitals). Although *Hallie* discussed the state action doctrine in respect to municipalities, public hospitals are state actors, rather than private parties acting on behalf of the state. Therefore, arguably only the first prong of the *Midcal* test would need to be satisfied. *See supra* notes 140-143 and accompanying text.

158. *See* Patrick v. Burget, 468 U.S. 94, 102-03 (1988) (finding Oregon statutory scheme did not satisfy the active supervision requirement of the *Midcal* test).

159. *Id.* at 103-04. In *Patrick,* the Court remarked in *dicta* that, although most prior cases

The Seventh Circuit applied the *Midcal* test in *Marrese v. Interqual, Inc.*,[160] to determine whether the revocation of staff privileges was protected from antitrust challenge under the state action doctrine.[161] Dr. Marrese, an orthopedic surgeon specializing in spinal disorders, enjoyed hospital staff privileges at Deaconess Hospital, a nonprofit corporation in Evansville, Indiana.[162] In February of 1978, the hospital selected members of the medical staff to form a Special Ad Hoc Committee ("SAHC") which conducted an audit of the spinal surgeries at Deaconess. The audit revealed problems concerning Marrese's operations. The SAHC recommended continued monitoring of Marrese's "lumbar laminectomy and spinal fusion" cases, and eventually retained the independent medical auditing firm of Interqual, Inc. to perform another audit of Marrese's surgeries in 1980.[163] Based upon negative findings by Interqual, the SAHC recommended revocation of staff privileges to the Medical Staff Executive Council, which adopted the recommendation, but stayed enforcement pursuant to the hospital's fair hearing plan.[164] However, prior to the final decision of the Board of Directors, Marrese filed suit alleging antitrust violations under sections 1 and 2 of the Sherman Act.[165]

In order to determine whether Deaconess' use of a peer review committee to make staff decisions satisfied *Midcal* and was therefore protected by the state action doctrine, the court made an extensive analysis of the Indiana statutory scheme governing practitioner and hospital licensing in light of *Midcal*.[166] The court held that the first prong of *Midcal* was satisfied, primarily because the Indiana statutory scheme mandated the review of hospital staff, as well as their diagnostic and surgical procedures.[167] Also,

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involved administrative agency review, "state action" may also be judicial review of private hospital decisions. *Id.* However, the Court declined to decide when, if ever, such judicial review would satisfy the state action doctrine, and merely stated that in this case it did not. *Id.*

160. 748 F.2d 373 (7th Cir. 1984), *cert. denied,* 472 U.S. 1027 (1985).

161. *Id.* at 387-91. Although noting that the Indiana statutes clearly authorized hospitals to establish and use peer review committees, the court stressed the necessity of determining "whether the defendants' conduct is 'clearly articulated and affirmatively expressed as [Indiana] state policy' and 'actively supervised' by the State so as to be exempt from the Federal antitrust laws under the doctrine of state action." *Id.* at 384.

162. *Id.* at 374-75. Marrese was licensed to practice in Illinois and Indiana, and was the sole shareholder of Bone & Joint Surgeons, Inc., in Evansville, Indiana. *Id.* at 374.

163. *Id.* at 375.

164. *Id.* The Fair Hearing Plan essentially allows practitioners a full evidentiary hearing and appeal. *Id.* at 375-76. The intricate procedure established at the hospital is pursuant to Indiana law as set forth in IND. CODE § 34-4-12.6-2(b) requiring an opportunity for a hearing. *Id.* at 376.

165. *Id.* at 377. Marrese brought antitrust allegations against "Interqual, Inc., Deaconess Hospital and its Board of Directors in their individual capacity, and members of the SAHC and Executive Committee at Deaconess, including seven doctors, one hospital administrator, and one attorney." *Id.* The court made clear in a footnote that at the time suit was filed, Dr. Marrese's staff privileges had not yet been revoked. *Id.* at 375 n.1.

166. *Id.* at 387-89.

167. *Id.* at 388 (citing IND. CODE §§ 16-10-1-6.5 and 34-4-12.6-1 (1982)). The court emphasized

the court implied that Indiana's grant of good faith immunity to participants of peer review committees,[168] as well as the importance of encouraging peer review in general,[169] further demonstrated that peer review was a "clearly articulated" policy of the state of Indiana.[170]

The court next analyzed the Indiana statutes to determine whether they set up a structure of "active supervision" as required by the second prong of *Midcal*.[171] Essentially, the court found that the requisite "active supervision" was supplied by two separate statutory entities:[172] the Indiana Medical Licensing Board[173] and the Hospital Licensing Council.[174] The court held that Indiana Medical Licensing Board supplied one form of supervision because it "enacts, promulgates, and enforces" licensing rules for practitioners, and it is also entitled to inspect peer review records of hospitals.[175] The Hospital Licensing Council, responsible for enacting rules and regulating the licensing of hospitals, was another form of supervision, according to the court, because it regularly inspected hospital records generally, including peer review records.[176] Because the court found both prongs of *Midcal* satisfied, the peer review activities of Deaconess hospital and the other named defendants were protected under the state action doctrine.[177]

The *Marrese* decision was followed in the Seventh Circuit[178] despite some criticism that the court misapplied the *Midcal* analysis.[179] However, *Marrese*

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that:

> [A]s a necessary and reasonable consequence of this state mandated medical peer review process, hospital staff members must review the medical treatments, diagnostic procedures, and surgical procedures of competing staff members and, when required, recommend the revocation of staff privileges. Thus, the defendants' conduct . . . in reviewing Dr. Marrese's surgical procedures and recommending that his staff privileges be revoked, satisfies the first element of the *Parker* test.

Id. at 388-89.

168. IND. CODE §§ 16-10-1-6.5, 34-4-12.6-3 (1982).

169. *Marrese*, 748 F.2d at 391-92. The court stressed that "peer review is essential to the very lifeblood and heartbeat of medical competency and quality medical care in the State of Indiana and throughout the nation." *Id.* at 392.

170. *Id.* The court interpreted the good faith immunity provision as Indiana's acknowledgement of the potential antitrust implications of peer review. *Id.*

171. *Id.* at 389-90.

172. *Id.* at 390.

173. IND. CODE §§ 25-22.5-2-7(h), 25-22.5-6-2.1, 34-4-12.6-2(b) (1982).

174. *Id.* §§ 16-10-1-1, 16-10-1-3, 16-10-1-12.

175. *Marrese*, 748 F.2d at 389-90. "The examination of confidential peer review data and records is an essential element of the Board's function in regulating the medical profession and in assuring that the citizens of Indiana receive the highest quality of medical care." *Id.* at 389.

176. *Id.* at 389-90. The court concluded that Indiana, "through the Hospital Licensing Council, promulgates standards of proper hospital care, regulates the licensing of hospitals within the State, and, as an integral part of its hospital inspection program, reviews the confidential records of medical peer review committees." *Id.* at 390. *See* Miles & Philp, *supra* note 17, at 507.

177. *Marrese*, 748 F.2d at 391.

178. *See, e.g.*, Ezpeleta v. Sisters of Mercy Health Corp., 621 F. Supp. 1262 (N.D. Ind. 1985), *aff'd*, 800 F.2d 119 (7th Cir. 1986).

179. *See* Quinn v. Kent General Hosp., 617 F. Supp. 1226 (D. Del. 1985); Miles & Philp, *supra* note 17, at 506-07.

failed to supply objective guidelines or suggest a model statutory structure in order to provide consistency. Indeed, the court left various questions open to interpretation. First, although *Marrese* implied that a statute creating good faith immunity for peer review participants would establish "clear articulation,"[180] at least one court has disagreed.[181] Also, *Marrese* arguably relaxed the *Midcal* requirement of "active supervision" when it held that mere access to peer review records satisfied this requirement.[182]

Three years later, the Seventh Circuit was given the opportunity to answer these questions in *Tambone v. Memorial Hospital for McHenry County.*[183] Unlike *Marrese,* Dr. Tambone's hospital staff privileges had actually been revoked as a result of a series of hearings instigated in 1974 by Memorial Hospital in Woodstock, Illinois.[184] In determining whether the state action doctrine insulated the defendants' actions from Tambone's antitrust challenge,[185] the court held *Marrese* controlling and proceeded to apply the *Midcal* analysis to the Illinois statutory scheme.[186]

The Seventh Circuit simply affirmed the district court's extensive analysis[187] as to whether the Illinois statutory scheme satisfied the first prong of *Midcal.*[188] Before 1983, Illinois had no statute that required or regulated peer review activities. Rather, there was a broad delegation of authority to the Director of the Department of Public Health to regulate the operation of Illinois hospitals.[189] Although the Director had promulgated rules requiring peer review pursuant to this authority,[190] the court found "such a broad,

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180. *See supra* note 132 and accompanying text.

181. *Quinn,* 617 F. Supp. at 1234.

182. As Miles & Philp note, the "active supervision" supplied by the then-existing Indiana statute was dubious. Miles & Philp, *supra* note 17, at 506-07. Although the statutes required inspection of hospital records generally by the Hospital Licensing Council, they merely *allowed* disclosure of peer review records to the Indiana Medical Licensing Board. Consistent review of records was essentially assumed by the court, although it appeared "highly unlikely that the state would ever learn of the hospital's credentialing proceedings, much less that it could correct an abuse even if it were discovered." *Id.* at 507.

183. 825 F.2d 1132 (7th Cir. 1987).

184. Tambone v. Memorial Hosp. for McHenry County, 635 F. Supp. 508, 509 (N.D. Ill. 1986), *aff'd,* 825 F.2d 1132 (7th Cir. 1987). The records of the hospital's Credentials and Nominating Committee indicated that the committee "found Dr. Tambone 'unqualified as to competency and professional standing' and recommended to the hospital's medical staff that his application be rejected." *Id.* at 510.

185. Dr. Tambone filed suit against Memorial Hospital for McHenry County, the Kishwakee Valley Medical group and the hospital peer review committee members. 825 F.2d at 1133. He alleged a conspiracy among the defendants to make it impossible for him to practice medicine in Woodstock, in violation of section 1 of the Sherman Act. *Id.* The defendants, relying on *Marrese,* claimed their actions as peer review members were exempt from antitrust liability based on the state action doctrine. *Id.* at 1134.

186. *Id.* at 1133. Essentially, the district court outlined the Indiana statutory system that existed in *Marrese* as a basis of comparison with the Illinois statutory system. *Id.* at 1134.

187. *Tambone,* 635 F. Supp 508 (N.D. Ill. 1986).

188. 825 F.2d 1132, 1134 (7th Cir. 1987).

189. *Tambone,* 635 F. Supp. at 511-12.

190. *Id.* at 511-12. The Director's regulations regarding peer review were mandatory. "These

amorphous grant of authority" insufficient to establish "clear articulation" of Illinois state policy.[191] The court, relying on *Southern Motor,* held that the articulation must be traced to the legislature.[192]

However, the district court, relying on *Marrese* found that the Illinois statute granting good faith immunity[193] was "sufficient" to satisfy the first prong of *Midcal.*[194] The Seventh Circuit agreed that statutory good faith immunity could establish "clear articulation" because such statutes "demonstrate[] a state policy in favor of peer review committees by providing good faith immunity from civil damages to members of such committees."[195] However, such a statutory grant of good faith immunity was insufficient to satisfy the "active supervision" prong of the *Midcal* test.[196]

The Seventh Circuit essentially agreed with the district court's finding that the Illinois statutes did not provide active supervision of the peer review process prior to 1983.[197] Indeed, all of the statutes and regulations presented by the defendants were concerned only with the licensing of hospitals and doctors, not peer review.[198] At most, these statutes indicated that prior to 1983, the Illinois statutes "may have tolerated" the existence of peer review, which was found not satisfactory as "active supervision."[199]

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regulations clearly indicate that peer review committees are a functional necessity if Illinois hospitals are to comply with the regulations issued by the Director of the Illinois Department of Public Health." *Id.* at 512.

191. *Id.* at 513.

192. *Id.* at 510. The court explained as follows:

> To meet the first prong of the state action test, the policy invoked must be clearly articulated by the state itself. Thus, if the source of the policy is the state legislature, the policy must be clearly embodied in a statute. . . . Although the details of how the anticompetitive conduct may be pursued can be left to regulation by state agencies, state agencies acting alone cannot immunize anticompetitive conduct. The intent to condone the challenged conduct must be clearly articulated by the legislature itself.

Id. (citations omitted).

193. ILL. REV. STAT. ch. 111, para. 4406 (1978) (this statute has since been repealed, however the analysis remains the same for purposes of this Note).

194. *Tambone,* 635 F. Supp. at 513. Indeed, although the *Marrese* court implied that such statutes would be useful in establishing clear articulation of policy, the district court asserted that such statutes were a "clear expression" of state policy. *Id.*

The court did, however, acknowledge that at least one court has disagreed with this approach. *Id.* at 513 n.2 (citing Quinn v. Kent General Hosp., Inc., 617 F. Supp. 1226 (D. Del. 1985)). The *Quinn* court's approach requires a clear statutory indication that the legislature intended to displace competition, rather than mere authorization or promotion of the peer review process. 617 F. Supp. at 1238-39. The district court in *Tambone* considered this approach "ill-founded." 635 F. Supp. at 513 n.2.

195. *Tambone,* 825 F.2d at 1134.

196. *Id.*

197. *Id.* at 1135. In 1983, the Illinois legislature passed ILL. REV. STAT. ch. 111, para. 4437(a)(1), which made reports to the Illinois State Medical Disciplinary Board of hospital peer review determinations mandatory. *Id.* at 1134-35.

198. *Id.* at 1134.

199. *Id.* at 1135. The district court found two distinguishing features between the Illinois

III. PATRICK v. BURGET

A. Facts and Procedural History

Dr. Timothy Patrick, a general and vascular surgeon, came to Astoria, Oregon in 1972.[200] He joined the staff at Astoria Clinic and received staff privileges at Columbia Memorial Hospital.[201] Columbia Memorial was the only hospital in Astoria.[202] The majority of Columbia Memorial's medical staff were also partners or employees of the Astoria Clinic.[203] In 1973, at the expiration of his one year contract, Dr. Patrick was invited to become a partner at the clinic. Patrick refused the invitation and opened a private practice which competed with the Clinic from 1979 to 1981.[204]

Over the years, the relationship between Dr. Patrick and the physicians at Astoria Clinic was strained and turbulent.[205] The clinic physicians did not refer patients to Dr. Patrick, but to other general surgeons over 50 miles away.[206] At the same time, they were reluctant to accept referrals from

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and Indiana statutory scheme existing prior to 1983 which lent support to the court's conclusion that inspection of peer review records was more likely to occur under Indiana's structure. *Tambone,* 635 F. Supp. at 515. As the district court illustrated:

> First, although transmission of all adverse peer review determinations to the Indiana Medical Licensing Board did not become mandatory until 1983 . . . , the predecessor statute . . . clearly contemplated the routine forwarding of peer review materials to appropriate registration and licensure boards for action by the state. No such statute or regulation, permissive or mandatory, appears to have existed in Illinois. . . . Second, review of Indiana hospitals by representatives of the State Board of Health was and still is required on a periodic basis. Inspections by the Illinois Department of Health were and still are discretionary.

Id. (citations omitted).

The Court of Appeals noted yet another distinction: the statutory right of appeal to Indiana state courts from adverse peer review decisions. *Tambone,* 825 F.2d at 1134.

200. Patrick v. Burget, 800 F.2d 1498 (9th Cir. 1986), *rev'd,* 486 U.S. 94 (1988). Astoria is a city of 10,000 people located in Northwest Oregon. 800 F.2d at 1502.

201. *Id.*

202. *Id.* The next nearest primary hospital was Ocean Beach Hospital in Ilwaco, Washington. Columbia Memorial was a secondary hospital capable of handling some types of complex surgery. *Id.*

203. *Id.* The other physicians at the clinic named as defendants in the suit include William Burget, Jorma Leinasser, Richard Kettlekamp, Patrick Meyer, Gary Boelling, Robert Niekes, Franklin Russell, Leigh Dolin, Richard Harris, Daniel Rappaport, and Tzu Sung Chiang. *Id.*

204. *Id.* Dr. Patrick chose to open an independent practice because he believed he had not been paid enough in relation to the income he had produced for the clinic. *Id.* Dr. James Weber worked for Dr. Patrick as a general surgeon for three years until he was fired in 1981. Dr. Weber then established his own independent practice in Astoria. *Id.*

205. *Id.* The court noted that the clinic physicians "reacted negatively" to Dr. Patrick's independent practice. *Id.*

206. *Id.* The clinic physicians were said to react angrily if Dr. Patrick treated any clinic patient. Confrontations resulted from the alleged theft of patients. *Id.*

Patrick.[207] Clinic physicians contended that they did not want to deal with Patrick because of his "contentiousness and lack of skill."[208]

In 1979, the bad feelings between Patrick and the clinic physicians escalated.[209] Eventually, Columbia Hospital reported Patrick to the Oregon Board of Medical Examiners ("BOME")[210] over his handling of the "Willie" case[211] and fourteen other cases.[212] A physician on the staff of Astoria clinic, Dr. Russell, chaired the BOME investigative committee.[213] The BOME issued Patrick a letter of reprimand based on the fifteen cases.[214] Patrick thought the review pertained only to the Willie case.[215] He objected to the letter and requested a new hearing.[216] Dr. Tanaka, BOME chairman, agreed the letter was erroneous but refused to withdraw it.[217] Only after Patrick filed a petition for judicial review did the BOME retract the letter.[218]

After the BOME investigation, Patrick's problems with the clinic physicians continued. At Columbia Hospital, Patrick's cases were closely monitored while the cases of other physicians with serious problems were unreviewed.[219] In 1981, the medical staff instituted proceedings to terminate

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207. *Id.* For example, the clinic physicians refused to treat Dr. Patrick's patients when he was out of town. *Id.*

208. *Id.*

209. *Id.* at 1503. The clinic physicians attacked Dr. Weber in various ways. However, as soon as Dr. Weber left Dr. Patrick's employment, he was asked to join the clinic staff. *Id.*

210. *Id.* Hospitals are common sources of information for state medical boards. Over 40 states require hospitals to report revocations of staff privileges. *See* Newald, *Watchful Eyes to Follow Physicians Through '87,* HOSPITALS, Jan. 5, 1987, at 49.

211. 800 F.2d at 1503. After performing an operation on Mr. Willie, Dr. Patrick went away for the weekend and left his associate, Dr. Weber, in charge of the case. Dr. Weber checked Mr. Willie on Sunday morning before he also left town. Dr. Weber left Dr. Linehan, a general practitioner, in charge of the case. Dr. Patrick was due back on Sunday afternoon. Mr. Willie's condition suddenly deteriorated. Dr. Linehan, feeling unsure of his competency to handle the situation, asked Dr. Boelling for help. Boelling declined and Dr Harris, a clinic physician, was assigned to the case by the hospital chief of staff. Boelling complained to the hospital over the handling of the Willie case. This incident prompted the reporting of Dr. Patrick to the BOME. *Id.*

212. *Id. See also* Dolin, *Antitrust Law Versus Peer Review,* 313 NEW ENG. J. MED. 1156 (Oct. 31, 1985) *(Patrick* defendant discussing two other cases of Dr. Patrick which were reported to BOME).

213. 800 F.2d at 1503.

214. *Id.* The letter, drafted by Dr. Russell and edited by the BOME administrator, criticized Dr. Patrick's handling of the Willie case and noted that Patrick was generally careless in his medical practices. *Id.*

215. *Id.*

216. *Id.* A meeting was held with Dr. Tanaka, the BOME chairman, where Dr. Patrick admitted that the BOME's criticism of the Willie case was justified. *Id.*

217. *Id.* Dr. Tanaka admitted the letter overstated the matters but refused to retract it because Dr. Russell indicated he knew of other cases of Patrick's that merited the criticism. *Id.*

218. *Id.*

219. *Id.* at 1503-04. The unequal treatment by the peer review committee was evidenced by a series of incidents involving Dr. McLaughlin. McLaughlin, an alcoholic who could not be reached during drinking binges, suffered a breakdown during an operation, and appeared in

Patrick's staff privileges at the hospital, alleging that Patrick's patients received substandard care.[220] The charges against Patrick focused on approximately nine cases.[221] Patrick was granted a hearing by the termination committee but the physicians at the hearing were uncooperative.[222] Not wanting a revocation of privileges to appear on his record, Patrick resigned from Columbia Hospital before the committee rendered its decision.[223]

In 1981, Patrick filed suit in federal district court challenging the peer review committee's actions and the impending termination of his privileges.[224] He alleged that the partners of the Astoria Clinic violated sections 1 and 2 of the Sherman Act.[225] The jury returned a verdict in favor of Dr. Patrick.[226]

On appeal, the United States Court of Appeals for the Ninth Circuit reversed the trial court.[227] The Ninth Circuit acknowledged that there was substantial evidence that the defendants had acted in bad faith.[228] However, the court held the committee to be immune from antitrust liability based on the state action doctrine.[229] The court interpreted Oregon statutes as establishing a policy that compelled physicians to review their competitors.[230] Thus, the policy satisfied the clear articulation prong of the *Midcal* test.[231]

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the emergency room intoxicated. He failed to report his drinking problems to the BOME. None of the incidents were scrutinized by the hospital peer review committee. In fact, McLaughlin received a substantial number of referrals from Astoria Clinic. He was even elected Chief of Staff of the hospital. *Id.* at 1504 n.4.

220. *Id.* at 1504.

221. *Id.* Patrick performed between 2,000 and 2,500 surgeries during the relevant time period. At trial, the court held that the jury easily could have concluded that the errors in the nine cases did not justify termination of Patrick's staff privileges. *Id.*

222. *Id.* The committee was said to be "inattentive" while Patrick was trying to present his defense. Furthermore, when requested to testify by Patrick's attorney, committee members refused to comment on the cases or their relationships with Patrick. Patrick was convinced that the outcome of the hearing was "preordained." *Id.*

223. *Id.* Patrick was later granted staff privileges at Ocean Beach Hospital.

224. *Id.*

225. *Id.* at 1504. Patrick also alleged violations of state law. *Id.*

226. *Id.* at 1504-05:

> The jury returned a verdict against Drs. Russell, Boelling and Harris on the section 1 count, against the 'The Astoria Clinic' on the section 2 count, and awarded Patrick $650,000 for the antitrust violations, which the court trebled. The jury also awarded $20,000 in compensatory and $90,000 in punitive damages against Boelling, Russell and Harris on the state law claim. The court awarded Patrick $228,600 in attorney's fees.

Id.

227. *Id.* at 1501-02.

228. *Id.* at 1507. The Ninth Circuit acknowledged that substantial evidence showed that the defendants had acted with bad faith in both the peer review process and the BOME proceedings. *Id.*

229. *Id.* at 1501.

230. *Id.* at 1505-06. "Oregon, by compelling physicians to review their competitors, affirmatively has expressed a policy to replace pure competition with some regulation." *Id.* (footnote omitted).

231. *Id.* For discussion of the *Midcal* test, see *supra* notes 131-33 and accompanying text.

The court also held that Oregon actively supervised the peer review process.[232] All adverse staffing decisions were reported to the BOME per Oregon statutes.[233] Furthermore, adverse staffing decisions were held to be judicially reviewable by courts.[234] The Ninth Circuit found that hospital review, BOME review, and judicial review constituted active state supervision thereby satisfying the second prong of the *Midcal* test.[235] Because both prongs of the *Midcal* test were satisfied, the court of appeals held that the members of the peer review committee had immunity from antitrust liability.[236]

B. Supreme Court's Holding

The United States Supreme Court reversed the Ninth Circuit and held that the state action doctrine did not protect Oregon physicians from federal antitrust liability for their peer review activities.[237] Addressing only the second prong of the *Midcal* test,[238] the Court held that no state actor actively supervised the peer review decision process of Oregon hospitals.[239] Consequently, no immunity could be afforded under the state action doctrine. In its analysis, the Court defined the active supervision prong of the *Midcal* test in two parts: first, the state must have the power to review the decision; and second, the state must have power to disapprove the peer review action.[240] To apply the test, the Court examined the role of three possible state actors and held that none actively supervised peer review activities.[241] Finally, the Court noted that policy issues raised by exposing the health care industry to antitrust liability should be directed to Congress.[242]

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232. *Id.* at 1506. Oregon hospitals are under a statutory obligation to establish peer review procedures and to review those procedures on a regular basis. *See* OR. REV. STAT. § 441.055(3)(c)-(d) (1987).

233. 800 F.2d at 1506. *See* OR. REV. STAT. § 441.820(1) (1987) (requiring prompt written report anytime health care facility restricts or terminates physician's privileges).

234. 800 F.2d at 1506. "Oregon courts have reviewed adverse privilege decisions to determine if they were made in good faith pursuant to fair procedures and were supported by the facts." *Id.*

235. *Id.*

236. *Id.* at 1507 ("[a]ctions within the scope of a state official's authority, taken pursuant to express state policy, which are contemplated by the statutory scheme, are actions of the state and therefore immune").

237. 486 U.S. 94, 105 (1988).

238. The Court stated that the "clear articulation" prong of the *Midcal* test need not be considered because the "active supervision" prong was not satisfied. *Id.* at 100.

239. *Id.* at 105.

240. *Id.* at 101. "The active supervision prong . . . requires that state officials have and exercise power to review particular anticompetitive acts of private parties and disapprove those that fail to accord with state policy." *Id.*

241. *Id.* at 1663-65. The three state actors examined by the Court were the Oregon Health Division, the BOME, and the state judiciary system.

242. *Id.* The Court was "not unmindful" of the policy argument that subjecting peer review members to antitrust liability may have a chilling effect on peer review activities. *Id.*

In examining the first possible state actor, the Supreme Court considered the Oregon Health Division, which has general supervisory powers over all health matters in the State.[243] Oregon law requires health care facilities to establish peer review procedures and to periodically review those procedures.[244] In its general supervisory capacity, the Health Division ensures that such committees are established.[245] However, because the Health Division has no statutory power to review or alter peer group decisions, the Court concluded that it was not a state actor capable of satisfying the active supervision requirement.[246] Statutory authority over peer review procedure does not constitute active supervision of private privilege determinations.[247]

Oregon law also requires that any termination or restriction of staff privileges be reported to the BOME.[248] However, Oregon law does not give the BOME the authority to review staff decisions.[249] There was no indication

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243. OR. REV. STAT. § 431.110(1) (1987) (giving the Health Division "direct supervision of all matters relating to the preservation of life and health of the people of the state").

244. OR. REV. STAT. § 441.055(3)(c)-(d) (1987):

> (3) The governing body of each health care facility shall be responsible for the operation of the facility, the selection of the medical staff and the quality of care rendered in the facility. The governing body shall:
>
> (c) Insure that procedures for granting, restricting and terminating privileges exist and that such procedures are regularly reviewed to assure their conformity to applicable law, and
>
> (d) Insure that physicians admitted to practice in the facility are organized into a medical staff in such a manner as to effectively review the professional practices of the facility for the purposes of reducing morbidity and mortality and for the improvement of patient care.

Id.

245. OR. REV. STAT. § 431.150(2) (1987).

246. *Patrick,* 486 U.S. at 102. The Health Division's statutory authority over peer review was limited to authority over a hospital's procedures and did not extend to the actual decisions of the peer review committee. *Id.* In fact, the authority over the peer review procedure was itself limited and did not give the Health Division the authority to review the *quality* of the procedures. Instead, the Health Division was merely authorized to force a hospital to comply with its obligation to establish and review peer review procedures. *Id.* at 102 n.6.

247. *Id.* at 102. The Court stated, "[t]he state does not actively supervise a restraint by peer review committees unless a state official has and exercises ultimate authority over private privilege determinations." *Id.*

248. OR. REV. STAT. § 441.820(1)-(2) (1987):

> (1) When a health care facility restricts or terminates the privileges of a physician to practice medicine at that facility, it shall promptly report, in writing, to the Board of Medical Examiners for the State of Oregon all the facts and circumstances that resulted in the restriction or termination.
>
> (2) A health care facility which reports or provides information to the Board of Medical Examiners for the State of Oregon under this section and which provides information in good faith shall not be subject to an action for civil damages as a result thereof.

Id.

249. *Id.* at 103. "The apparent purpose of the reporting requirement is to give the BOME an opportunity to determine whether additional action on its part, such as revocation of a physician's license, is warranted." *Id.* (footnote omitted).

in the statute that the BOME could change a peer review committee decision.[250] Instead, the statute was primarily a reporting mechanism.[251] Thus, because the BOME did not actively supervise private peer review decisions, the Court held that the agency was not a state actor capable of satisfying the second prong of the *Midcal* test.[252]

The Supreme Court also considered whether the state judiciary possessed the necessary supervisory authority. State judicial review of privilege termination decisions, if it existed at all, was limited to a review of procedural reasonableness.[253] "Such constricted review," the Court stated, does not convert private decisions into state action.[254] The Court refused to decide whether judicial review of private conduct could ever constitute active supervision. Instead, it merely held that no such judicial review existed under Oregon statutes or case law.[255]

The Court recognized the policy argument that the quality of health care may decline if the threat of antitrust liability discourages physicians from participating in peer review proceedings.[256] The Court concluded, however, that any decision about the wisdom of applying the antitrust laws to the health care setting was best left to Congress.[257] The Court stated that unless Congress insulated peer review activities, each state would be responsible for this task by conforming with the state action doctrine.[258]

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250. *Id.*

251. *Id.*

252. *Id.* (noting that respondents did not show the BOME in practice has ever asserted any authority to review or reverse privilege decisions).

253. *Id.* at 104-05. The Court considered two Oregon Supreme Court decisions, Straube v. Emanuel Lutheran Charity Bd., 287 Or. 375, 600 P.2d 381 (1979), and Huffaker v. Bailey, 273 Or. 273, 540 P.2d 1398 (1975), and noted that these courts assumed but did not decide whether a physician is entitled to review of peer review decisions. *Patrick,* 486 U.S. at 104-05. The *Straube* court, however, stated that a court "should [not] decide the merits of plaintiff's dismissal." *Straube,* 287 Or. at 384, 600 P.2d at 386.

254. *Patrick,* 486 U.S. at 105.

255. *Id.* at 104. *But see* Bolt v. Halifax Hosp. Medical Center, 851 F.2d 1273 (11th Cir 1988) (court found that Florida's statutory scheme which provided for probing judicial review board decisions constituted "active state supervision" sufficient to invoke state action doctrine), *vacated,* 874 F.2d 755 (11th Cir. 1989).

256. *Patrick,* 486 U.S. at 104.

257. *Id.*

258. *Id.* The Court acknowledged that Congress insulated certain medical peer review activities from antitrust liability in the Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101-11152 (Supp. V 1987). "The Act, which was enacted well after the events at issue in this case and is not retroactive, essentially immunizes peer-review from liability if the action was taken 'in the reasonable belief that [it] was in the furtherance of quality health care.'" 486 U.S. at 105 n.8. Because the Act expressly preserves other "immunities under the law," including the state action immunity, states may immunize peer review action that does not meet the federal standard. "In enacting this measure, Congress clearly noted and responded to the concern that the possibility of antitrust liability will discourage effective peer review. If physicians believe that the Act provides insufficient immunity to protect the peer review process fully, they must take that matter up with Congress." 486 U.S. at 105 n.8.

IV. ANALYSIS

A. State Statutes Did Not Constitute "Active Supervision"

In *Patrick,* the physician defendants on the peer review committee claimed immunity for their actions under the state action doctrine. When the Court rejected this defense it acted consistently with prior case law[259] and further defined the active supervision requirement. In so doing, the Court expanded the requirement of active supervision necessary to a defense based on the state action doctrine. To satisfy this prong of the *Midcal* test a defendant must now show that the state actor has both the power to review and the power to disapprove of a peer review decision.[260]

As previously mentioned, it is well settled that antitrust liability extends to professions.[261] However, *Patrick* represents the first United States Supreme Court case in which antitrust liability was extended to peer review committee members in a private hospital. The Court held that the state action doctrine did not protect the physicians from federal antitrust liability because the active supervision requirement of the *Midcal* test was not satisfied.[262] Peer review committee members, like any other defendant attempting to raise the state action doctrine defense, will receive immunity only if both prongs of the state action doctrine test are satisfied.[263]

The *Patrick* Court applied only prong two of the *Midcal* test.[264] Many previous Supreme Court decisions have stressed one prong of the state action doctrine over the other.[265] The reason this Court focused on the active supervision prong was because the defendants had not satisfied it, therefore it was unnecessary to consider the clear articulation prong.[266]

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259. *See, e.g.,* Southern Motor Carriers Rate Conference, Inc. v. United States, 471 U.S. 48 (1985) (collective ratemaking immune from antitrust liability under the state action doctrine); Town of Hallie v. City of Eau Claire, 471 U.S. 34 (1985) (municipality exempt from antitrust liability by state action doctrine); Hoover v. Ronwin, 466 U.S. 558 (1984) (state action found in admission procedure for Arizona State Bar); California Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97 (1980) (California's wine pricing system not immune under state action doctrine); Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975) (minimum fee schedule not exempt from antitrust liability under the state action doctrine).

260. Patrick v. Burget, 486 U.S. 94, 101 (1988).

261. *See, e.g.,* National Soc'y of Prof. Eng'rs v. United States, 435 U.S. 679 (1978); Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975).

262. Patrick v. Burget, 486 U.S. 94, 105 (1988).

263. *Id.* at 100.

264. *Id.* The Court stated that it need not consider the clear articulation prong of the *Midcal* test because the active supervision requirement was not satisfied. *Id.*

265. *See* Town of Hallie v. City of Eau Claire, 471 U.S. 34 (1985) (active supervision not a prerequisite to exemption for municipality); Southern Motor Carriers Rate Conference, Inc. v. United States, 471 U.S. 48 (1985) (clear articulation prong emphasized because respondent conceded active supervision prong); California Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97 (1980) (court imposed antitrust liability because no active supervision).

266. *Patrick,* 486 U.S. at 100.

In *Patrick,* the Court further developed the active supervision prong, by stating that the active supervision prong consisted of two requirements. First, state officials must "have and exercise power to review particular anticompetitive acts of private parties."[267] Second, state officials must have the power to "disapprove those [anticompetitive acts] that fail to accord with state policy."[268] According to the Court, active state supervision was necessary to a state action doctrine defense because only those anticompetitive acts which promote state policy are protected.[269]

The Court looked to the State Health Division, the BOME, and the state judicial system when it considered whether the state fulfilled the active supervision requirement over peer review activities.[270] In applying the *Midcal* test, the Court correctly concluded that the activities of the Health Division did not satisfy either requirement of the active supervision prong. The Health Division may have had the power to deny, suspend, or revoke the license of any hospital that did not establish peer review procedures as mandated by statute,[271] but it did not have the power to review private peer review decisions.[272] Also, there was no indication that the Health Division could change a peer review decision which failed to accord with state policy.[273] Thus, without the statutory authority to review or alter peer review decisions, the Court indicated the Health Division was not a state actor capable of satisfying the active supervision requirement of the *Midcal* test.

Moreover, the Court correctly concluded that the activities of Oregon's BOME did not satisfy either requirement of the active supervision prong. All decisions to terminate or restrict staff privileges were reported to the BOME as provided for by Oregon statute.[274] The Court stated that the respondents did not demonstrate that the BOME actively reviewed privilege decisions.[275] Rather, the BOME determined if further action should be taken against a physician such as revocation of a license. The Court also stated that no Oregon statute indicated that the BOME had the power to disapprove of a peer review decision.[276] Considering that the BOME did not actively

267. *Id.* at 101.

268. *Id.*

269. *Id.* (explaining that the active supervision requirement is designed to ensure that only those anticompetitive acts of private parties which further state regulatory policies will be sheltered).

270. *Id.* at 101-05. The Court stated that neither the Ninth Circuit nor the respondents indicated how any of these entities reviewed private hospital decisions. *Id.*

271. *Id.* at 102. The Health Division had general supervisory power. It licensed hospitals, enforced health laws, and could sanction any hospital that failed to establish peer review committees. *Id.*

272. *Id.*

273. *Id.*

274. *Id.* at 103. The Court found that OR. REV. STAT. § 441.820(1) required that all decisions by Oregon hospitals be reported to the BOME that involved a restriction or termination of a physician's privileges. *Id.*

275. *Id.* at 103.

276. *Id.*

review or reverse staff privilege decisions by peer review committees, the Court held the BOME was not a state actor capable of satisfying the active supervision prong of the *Midcal* test.

The *Patrick* Court offered no example of a state statutory scheme in which immunity for peer review committees had been achieved through the state action doctrine. However, in *Marrese v. Interqual, Inc.*, the Seventh Circuit had previously held that Indiana's statutory scheme—which mandated and actively supervised medical peer review activities—satisfied the active supervision prong of the state action doctrine.[277] For example, Indiana as a matter of state policy mandated that hospital medical staffs form peer review committees.[278] In addition, the Indiana Medical Licensing Board enacted, promulgated, and enforced rules of competent medical practice within the state and monitored review committee records.[279] Furthermore, the Indiana Hospital Licensing Council, in addition to establishing standards for hospitals, reviewed the records of peer review committees.[280]

The Court of Appeals for the Seventh Circuit held that the peer review committee in *Marrese* was exempt from federal antitrust liability because the extensive statutory scheme of Indiana satisfied the state action doctrine.[281] Interestingly, the Ninth Circuit in *Patrick* found the Oregon statutory scheme very similar to the Indiana statutes.[282] The Supreme Court, however, held that the Oregon scheme was not sufficient to satisfy the active supervision prong of the state action doctrine.[283] It follows, therefore, that *Marrese* would be decided differently today, and that the Indiana statutes, like the Oregon statutes, would not satisfy the state action doctrine.

B. Judicial Review

In *Patrick,* the Court did not decide the broad issue of whether judicial review of a private staff privilege decision would ever amount to state action. Instead, the Court held that the judicial review in Oregon as it existed, fell short of satisfying the active supervision requirement of the *Midcal* test.[284] The Court initiated its analysis of judicial review by looking for statutory mandates for review of private staffing decisions. The Court concluded that there was no express statute providing for judicial review of private staffing decisions in Oregon to satisfy the active supervision requirement.[285]

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277. Marrese v. Interqual, Inc., 748 F.2d 373, 388 (7th Cir. 1984), *cert. denied,* 472 U.S. 1027 (1985).

278. *See supra* note 167 and accompanying text.

279. *See supra* notes 171-77 and accompanying text.

280. *Id.*

281. *Id.*

282. Patrick v. Burget, 800 F.2d 1498, 1506 (9th Cir. 1986) (finding Indiana's statutory scheme "nearly identical" to Oregon's), *rev'd,* 486 U.S. 94 (1988).

283. *Patrick,* 486 U.S. at 105.

284. *Id.* at 105.

285. *Id.* Oregon had no express statute providing for judicial review of staff privilege termination decisions.

The Court next turned to Oregon case law to determine if judicial review satisfied the active supervision requirement. The Court noted that Oregon courts had never affirmatively held that a physician in a private hospital whose privileges were revoked could seek relief in court.[286] For example, in *Huffaker v. Bailey,* the Oregon Supreme Court merely held that as long as a denial of privileges was made in good faith and supported by fact, courts should not invalidate it.[287]

Similarly, in *Straube v. Emanuel Lutheran Charity Board,* the Oregon Supreme Court again advocated judicial restraint.[288] The *Straube* court clearly stated that it had not decided whether a physician was entitled to judicial review as a common law right.[289] Instead, the Oregon Supreme Court stated that a court should not decide the "merits" of a staff privilege case but rather limit its inquiry to determining if "reasonable procedure" was afforded to a physician.[290]

After considering these decisions, the Supreme Court remarked that *Huffaker* and *Straube* advocated judicial restraint and thus failed to meet the active supervision prong of the *Midcal* test.[291] Moreover, the Court stated that Oregon courts indicated that even if they provided judicial review, it would be a very limited review and would avoid the merits of a decision.[292] The Court stated that such limited review would not satisfy the active supervision requirement[293] because the active supervision prong requires a defendant to show both the power to review and the power to disapprove. According to the Court, merely reviewing procedural aspects of a peer review decision does not constitute power to disapprove the merits of the decision.[294] When it analyzed Oregon's judicial review, the *Patrick* Court made an important distinction between procedural review and review on the merits of a case with regards to the state supervision requirement. By rejecting procedural review as too constricted, it follows that a broader review of the merits of a case might satisfy the active supervision requirement.[295] However, the Court's reluctance to decide this question raises the additional question of how broad a review on the merits need be before it constitutes active supervision.

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286. *Id.*

287. Huffaker v. Bailey, 273 Or. 273, 280-81, 540 P.2d 1398, 1399 (1975).

288. 287 Or. 375, 383, 600 P.2d 381, 386 (1979).

289. *Id.* at 375, 600 P.2d at 384.

290. *Id.* at 384, 600 P.2d at 386.

291. *Patrick,* 486 U.S. at 105.

292. *Id.* at 104.

293. *Id.* at 105.

294. *See infra* notes 295-301 and accompanying text.

295. *Patrick,* 486 U.S. at 105. Although not explicitly endorsing review on the merits, the Court stated, "[u]nder the standard suggested by the Oregon Supreme Court, a state court would not review the merits of a privilege termination decision to determine whether it accorded with state regulatory policy." *Id. See also* Cross & Berman, *Hospital Peer Review and the State Action Doctrine After* Patrick, 3 ANTITRUST 14, 19 (Fall 1988).

Because the Court declined to address the broad issue of whether judicial review of a private staff privilege decision would ever satisfy the state action doctrine,[296] it also failed to provide examples of judicial review which might satisfy the requirements of the *Midcal* test. Accordingly, whether state action would be found in states following the minority approach—which subjects the staffing decisions of private hospitals to judicial scrutiny—is not clear.[297] Without affirmative guidance from the Court, lower courts in states subscribing to the *Greisman*[298] philosophy must infer the standard which would satisfy the *Midcal* test.[299] If judicial review is such that it may consider and reverse the peer review decision based on the merits, it follows that such judicial review would satisfy the test. Whether the *Greisman* approach is an example of such judicial review is less clear. The general rule is that peer review committees receive great deference in their decisions.[300] The *Greisman* line of cases provides broader review than the majority and refuses to distinguish between public and private hospitals.[301] Nevertheless, even those courts which review private hospital decisions afford deference to the hospitals on the merits, reasoning that these types of decisions are better left to professional judgment.[302] Under the *Patrick* Court's requirements, quite possibly, no jurisdiction's judicial review will satisfy the active supervision prong of the state action doctrine.

At present, courts still have not determined whether judicial review satisfies the active supervision prong of the *Midcal* test. However, in a decision now vacated, the Eleventh Circuit held, in *Bolt v. Halifax Hospital Medical Center,* that Florida's judicial review of staff privilege decisions constituted active supervision for purposes of the state action doctrine.[303] Although vacated on the issue of judicial review, the decision still merits consideration. The facts in *Bolt* were similar to those in *Patrick.*[304] Applying the first prong

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296. *Patrick,* 486 U.S. at 104. The Court acknowledged that it never previously considered whether state courts, acting in their judicial capacity, can ever satisfy the state action doctrine. All prior Supreme Court cases involved administrative agencies or state supreme courts acting in an agency-like capacity. *Id.*

297. *See supra* notes 50-54 and accompanying text.

298. *Id.*

299. The *Patrick* Court stated, when it referred to the limited review in Oregon, "[s]uch constricted review [where 'a state court would not review the merits of a privilege termination decision'] does not convert the action of a private party in terminating a physician's privileges into the action of the State for purposes of the state-action doctrine." *Patrick,* 486 U.S. at 105.

300. *See* Woodard v. Porter Hosp., Inc., 125 Vt. 419, 423, 217 A.2d 37, 40 (1966) (policies of a private hospital will not be subject to judicial review unless arbitrary, capricious, or discriminatory) (citing Greisman v. Newcomb Hosp., 40 N.J. 389, 192 A.2d 817 (1963)).

301. *See* Nodzenski, *supra* note 26, at 972-74 (discussing *Greisman* and the rationale behind the minority approach).

302. *See* Sosa v. Board of Managers of Val Verde Memorial Hosp., 437 F.2d 173 (5th Cir. 1971). *See also* Trail & Kelley-Claybrook, *supra* note 26, at 340.

303. 851 F.2d 1273, 1282 (11th Cir. 1988), *vacated,* 874 F.2d 755 (11th Cir. 1989).

304. Dr. Bolt had his staff privileges at three hospitals revoked for refusing to enter an

of the *Midcal* test, the Eleventh Circuit concluded that Florida law provided a clearly articulated state policy authorizing peer review.[305] In considering the second prong of the *Midcal* test, the Court noted that no Florida statute established a state program of active supervision over peer review decisions.[306] However, the court held that judicial review of staff privilege decisions by Florida courts constituted active supervision for purposes of the state action doctrine.[307] Florida courts had reviewed staff privileges decisions to determine if termination were based on fair procedures, valid criteria, and sufficient evidence.[308] Sitting *en banc,* the Eleventh Circuit vacated the portions of the *Bolt* decision dealing with judicial review.[309] Clearly the limited judicial review afforded by the Florida courts would not have satisfied the active supervision requirement as defined by the Supreme Court in *Patrick.* In *Patrick,* the Court indicated that a state court must review the merits of a staff privilege decision to satisfy the active supervision requirement.[310] The scope of judicial review afforded by Florida courts, which examines the fairness of procedure, validity of dismissal criteria, and the sufficiency of the evidence, does not include review of the merits of a staff privilege decision.[311]

Since *Patrick,* with the exception of the vacated *Bolt* decision, no lower court has held that judicial review may constitute active supervision to provide immunity under the state action doctrine.[312] Some courts simply refuse to address the issue.[313] In the alternative, other courts apply the strict standard set forth in the dicta of *Patrick,* that is, to qualify as active supervision, any judicial review would have to address the merits of the

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impaired physician's program as directed by a reappointment committee. Upon revocation of his privileges, Dr. Bolt filed suit against the hospitals, the medical staffs, and a local medical society based on antitrust claims. *Id.* at 1275-77.

305. *Id.* at 1281.

306. *Id.* at 1281-82. Section 458.337(1)(b) of the Florida statutes required that the Florida Board of Medical Examiners ("BOME") be notified whenever a physician was disciplined. However, the BOME had no power to overturn a peer review decision. FLA. STAT. § 458.337(1)(b) (1981). Thus, the BOME was not a state actor capable of satisfying the state action doctrine.

307. *Bolt,* 851 F.2d at 1283. Florida courts construe hospital bylaws as a contract between the physician and the hospital. A physician may obtain injunctive relief if a hospital revokes his privileges in violation of hospital bylaws. *Id.*

308. *Id.*

309. Bolt v. Halifax Hosp. Medical Center, 874 F.2d 755 (11th Cir. 1989). *See also* Cross & Berman, *supra* note 295, at 19 ("the *Bolt* decision may only serve to confuse the issues further").

310. 486 U.S. 94, 105. The Court indicated that limited judicial review of the reasonableness of the procedure afforded to a physician would not satisfy the active supervision requirement. *Id.*

311. *See Bolt,* 851 F.2d at 1284.

312. *E.g.,* Pinhas v. Summit Health, Ltd., 880 F.2d 1108 (9th Cir. 1989); Shahawy v. Harrison, 875 F.2d 1529 (11th Cir. 1989); Jiricko v. Coffeyville Memorial Hosp. Medical Center, 700 F. Supp. 1559 (D. Kan. 1988).

313. *E.g.,* Jiricko v. Coffeyville Memorial Hosp. Medical Center, 700 F. Supp. 1559, 1563 (D. Kan. 1988).

decision.[314] In applying this strict standard, these latter courts hold that since their judicial decisions involve procedural reviews, the active supervision prong as described in *Patrick* is not met.[315]

C. *The Health Care Quality Improvement Act of 1986*

With the strict standard set forth in *Patrick* and the uncertainty of the jurisdictional defense, the Health Care Quality Improvement Act of 1986[316] may be the most viable way of insulating peer review activities from antitrust liability. In a footnote, the *Patrick* Court referred to the Health Care Quality Improvement Act of 1986 as another possible way of insulating certain peer review activities from antitrust liability.[317]

Although the Court did not thoroughly explain the Act or its implications, it did acknowledge that the Act is based on a good faith standard as an effective method of providing immunity to peer review committees.[318] In this footnote, the Court went on to suggest that even if peer review activity did not meet the standards of the federal Act, states were not prevented from immunizing any peer review activity through the state action doctrine or

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314. *E.g., Pinhas,* 880 F.2d at 1113-14; *Shahawy,* 875 F.2d at 1535-36.

315. In California, judicial review is limited to "an examination of the record of the hospital proceedings to determine whether the action taken was substantially irrational, unlawful or contrary to established public policy or procedurally unfair." *Pinhas,* 880 F.2d at 1114. In Florida, judicial review occurs only when "a peer review board uses unfair or unreasonable procedures, or when a board arbitrarily or capriciously applies its procedures." *Shahawy,* 875 F.2d at 1536. *See* Note, *Judicial Review as* Midcal *Active Supervision: Immunizing Private Parties from Antitrust Liability,* 57 FORDHAM L. REV. 403 (1988). The author concludes that judicial review should satisfy the *Midcal* active supervision requirement. However, the author does not advocate stricter application of the *Midcal* test—that is, review on the merits. *Id.* at 423. Instead, the author stated that a review on the merits would either force a state to "install a full regulatory apparatus, or to withdraw in favor of competition." *Id.* at 422, n.125.

316. 42 U.S.C. §§ 11101-11152 (Supp. V 1987). *See supra* notes 77-83 and accompanying text for discussion of the Act.

317. *Patrick,* 486 U.S. at 105 n.8. *See also* Comment, *supra* note 36, at 1073. The author states that the Act provides immunity under federal and state law from damage suits against peer review groups and individuals acting in support of these groups, preserving only civil rights actions. *Id.* at 1091. Under the act, a physician in direct competition with the physician facing discipline is prohibited from sitting on the peer review panel. The author goes on to state:

> The grant of immunity in the Act is conditioned on two factors. First, a peer review group must provide sufficient due process protections to a physician subjected to peer review action. The Act specifically details the procedures Congress deemed to be appropriate due process, and creates a rebuttable presumption that the peer review group met the due process requirements even if the group did not follow the procedures in the Act. Second, the peer review group must take the disciplinary action in the reasonable belief that the action will further quality health care. . . . Part A also conditions the peer review group's immunity on faithful reporting of disciplinary action to the national data bank.

Id. at 1091-92.

318. *Patrick,* 486 U.S. at 105 n.8.

state immunity statutes.[319] However the Court offered little guidance as to the application and impact of the Act on this area of law.

The Court did not apply the Act in *Patrick* because it could not be applied retroactively to the events of the case.[320] Moreover, the Court gave no indication as to how the results in *Patrick* would have differed if the Act had been applied to the facts in the case. Instead, the Court relied solely on the state action doctrine. The Health Care Quality Improvement Act is largely based on a good faith standard.[321] Given the facts of *Patrick,* even if the Supreme Court could have applied the Act instead of the state action doctrine, arguably, the results would have been the same considering the bad faith review.[322]

V. SUBSEQUENT DECISIONS

Since *Patrick* was decided, a number of lower courts have applied the state action doctrine in cases dealing with physician staff privileges.[323] Thus far, no court has found a state statutory scheme to be comprehensive enough to provide defendants immunity from antitrust liability, in light of the strict standards set forth in *Patrick.* Essentially, the state statutory schemes fall short under the second prong of the *Midcal* test—the active supervision requirement.[324] For example, in *Shahawy v. Harrison,* the Eleventh Circuit recently analyzed the Florida peer review statutory scheme in terms of the active supervision requirement.[325] In that case, the court noted an abundance

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319. *Id.*

320. *Id.*; *see also* George, *supra* note 78, at 402. Immunity from damages under federal statutes is already effective. For state actions, the Act grants immunity only for actions commenced on or after October 14, 1989. A state may elect to have immunity provisions apply earlier. This would be accomplished by legislation. *Id.* In fact, Texas has adopted the provisions of the Health Care Quality Improvement Act by legislation. *See* TEX. REV. CIV. STAT. ANN. art. 4495b, § 5.06 (Vernon 1988). Oregon has not incorporated the provisions of the Act into its legislation.

321. 42 U.S.C. § 11112 (Supp. V 1987).

322. Patrick v. Burget, 800 F.2d 1498, 1507 (9th Cir. 1986) *rev'd,* 486 U.S. 94 (1988).

323. Pinhas v. Summit Health, Ltd., 880 F.2d 1108 (9th Cir. 1989) (California defendants not protected by state action doctrine); Shahawy v. Harrison, 875 F.2d 1529 (11th Cir. 1989) (Florida statutory scheme and judicial review did not protect defendants from antitrust liability); Bolt v. Halifax Hosp. Medical Center, 851 F.2d 1273 (llth Cir. 1988) (Florida defendants not protected by state action doctrine), *vacated,* 874 F.2d 755 (11th Cir. 1989); Jiricko v. Coffeyville Memorial Hosp. Medical Center, 700 F. Supp. 1599 (D. Kan. 1988) (Kansas defendants not protected by state action doctrine).

324. *See supra* note 240 and accompanying text.

325. 875 F.2d 1529 (11th Cir. 1989). In *Shahawy,* a physician, Mahfouz El Shahawy, and his medical association filed suit against the Sarasota County Public Health Board, the hospital's medical review committee members, and physicians on the hospital staff after he was denied cardiac catheterization laboratory privileges. *Id.* at 1531. His original action alleged antitrust, civil rights, racketeering, and state common law violations. *Id.* In this appeal, one of the issues was whether the district court had erroneously granted summary judgement in favor of the hospital board when it concluded that the state action doctrine immunized the hospital board from federal antitrust liability. *Id.* at 1534.

of Florida statutes dealing with the peer review process.[326] However, the court noted that one critical element was lacking—that is, no state official reviewed peer review decisions to determine if they were in line with state policy.[327] The court concluded that, in the absence of such active supervision by a state actor, the Florida statutory scheme was insufficient to provide immunity under the state action doctrine.[328] *Shahawy* is consistent with *Patrick* in holding that to satisfy the active supervision requirement, a state actor must review peer review decisions on their merits.[329] In fact, *Patrick* goes one step further by suggesting that inherent in the review process is the power and authority to change a decision that does not conform to state policy.[330]

Similarly, in *Pinhas v. Summit Health, Ltd.*,[331] a case analagous to *Shahawy,* the Ninth Circuit recently examined the California peer review statutory scheme and concluded that it too did not offer defendants immunity from antitrust liability under the state action doctrine.[332] As in *Patrick,* the court's analysis was limited to the second prong of the *Midcal* test.[333] The Ninth Circuit found California's peer review statutes to be virtually identical to those rejected by the Court in *Patrick.*[334] According to the court, California's peer review statutes fail to provide state action immunity because

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326. *Id.* at 1535. Specifically, the court noted three Florida statutory provisions: (1) FLA. STAT. ANN. § 395.011(6) (West 1986) required "all licensed facilities to set procedures and standards for determining staff membership and clinical procedures." *Id.* at 1535; (2) FLA. STAT. ANN. § 395.011(7) (West 1986) required "licensed facility which denies staff membership or clinical privileges must provide an applicant with written reasons for such denial." *Id.*; and, (3) FLA. STAT. ANN. § 395.011(7) (West 1986) required that "hospital board must report any denial of staff membership or clinical privileges to the state licensing board." *Id.*

327. *Id.*

328. *Id.*

329. *See supra* note 240 and accompanying text.

330. Patrick v. Burget, 486 U.S. 94, 101 (1988). "The active supervision prong . . . requires that state officials have and exercise power to review particular anticompetitive acts of private parties and disapprove those that fail to accord with state policy." *Id.*

331. 880 F.2d 1108 (9th Cir. 1989). Dr. Pinhas was an ophthalmologist who contended that his hospital staff privileges were wrongfully revoked by a peer review board when he refused to sign a contract with the defendant. *Id.* at 1110. Pinhas filed suit against several different defendants, including members of the peer review board, alleging violation of the antitrust laws and his due process rights. *Id.* at 1111. One of the issues on appeal was the dismissal of Pinhas' antitrust claim based on the state action doctrine. *Id.* at 1112.

332. *Id.* at 1113.

333. *Id.*

334. *Id.* The court concentrated on the activities of two California agencies. First, the State Department of Health Services ("SDHS") was responsible for licensing and reviewing hospital procedures. The court analogized the activities of the SDHS to those of the Oregon State Health Division in *Patrick. Id.* Secondly, the California Board of Medical Quality Assurance's ("BMQA") primary function was to regulate and discipline physicians within the state. Any adverse action taken by a hospital against a physician must be reported to the BMQA. The court stated that the activities of the BMQA were similar to those of the BOME in *Patrick. Id.*

no state actor actively supervises or reviews procedures.[335] Thus, the statutory interpretation engaged in by the *Pinhas* court, like that of the *Shahawy* court, is consistent with *Patrick*. Both *Pinhas* and *Shahawy* follow the strict active supervision standards as set forth in *Patrick*. Unfortunately, even though there are many examples of state statutory schemes that do not satisfy the *Patrick* requirements, as yet, there is not a concrete example of a peer review statutory scheme that is sufficient.

Because the Court in *Patrick* set such a strict standard for invoking the state action doctrine in defense of antitrust challenges to peer review activities, more defendants named in those suits may instead attempt to assert the jurisdictional defense.[336] As previously stated, to raise that defense defendants assert that their activities are inherently local, do not affect interstate commerce and therefore fall outside of the jurisdiction of the Sherman Act. Defendants may or may not prevail with this argument.[337] Since *Patrick,* at least one defendant hospital has successfully raised the jurisdictional defense. In *Mitchell v. Frank R. Howard Memorial Hospital,*[338] a radiologist sued a small, rural hospital after it entered into an exclusive arrangement agreement with another radiologist.[339] The Ninth Circuit affirmed a decision in favor of the defendant hospital holding that its activities did not, as a matter of law, have sufficient impact on interstate commerce to create jurisdiction under the Sherman Act.[340] The Ninth Circuit weighed a variety of factors and concluded that although this small, rural hospital might have purchased some out of state supplies and received out of state insurance payments, these factors alone were not sufficient to establish an impact on interstate commerce.[341] It remains to be seen if there will be an increase in the number

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335. The SDHS, like the State Health Division in *Patrick,* had no authority to review hospital staff decisions. *Id.* The BMQA, like the BOME in *Patrick,* had no authority to review the outcome of peer review proceedings. *Id.*

336. *See supra* notes 89-92, 111-119 and accompanying text.

337. *E.g.,* Pariser v. Christian Health Care Sys., Inc., 816 F.2d 1248, 1253 (8th Cir. 1987) (no substantial effect on interstate commerce where 98% of hospital's patients were Illinois residents); Doe *ex rel.* Doe v. St. Joseph's Hosp., 788 F.2d 411, 417 (7th Cir. 1986) (plaintiff did not allege facts sufficient to establish interstate nexus); Seglin v. Esau, 769 F.2d 1274, 1279 (7th Cir. 1985) (physician failed to allege facts to establish nexus with interstate commerce); Cardio-Medical Assocs., v. Crozer-Chester Medical Center, 721 F.2d 68, 75 (3d Cir. 1983) (plaintiff met jurisdictional requirements of Sherman Act).

338. 853 F.2d 762 (9th Cir. 1988), *cert. denied,* 109 S. Ct. 1123 (1989).

339. *Id.* at 763. Dr. Mitchell had an oral contract to provide radiology services to Howard Memorial Hospital which was a 38 bed rural facility. After the hospital terminated the contract, Dr. Mitchell sued under the Sherman Act.

340. *Id.* at 764. Dr. Mitchell unsuccessfully argued that because the hospital received a substantial portion of its $5,000,000 annual revenues from out-of-state public and private insurance programs, because the hospital purchased an unknown amount of medical supplies from out-of-state sources, and because the radiology department alone generated over $600,000 a year in revenue, the hospital's activities, although local in nature, substantially affected interstate commerce. *Id.*

341. *Id.* The court stated a sufficient impact on interstate commerce is measured by more

of defendants asserting this jurisdictional defense in the aftermath of *Patrick*.[342]

VI. IMPACT

Three things are clear from the *Patrick* decision. First, the activities of peer review committees may be subjected to a traditional antitrust analysis.[343] Second, the state action doctrine may provide immunity for peer review committees but only if the state or state actor provides for, and actively supervises, the process.[344] Finally, active supervision will be very difficult to prove. If a state statute or regulatory practice is to meet the active supervision prong of the *Midcal* test, it must provide the power of review and the power of reversal to a state actor.[345] Few, if any, statutory schemes meet this test. The same is true of the limited methods of judicial review currently available. As a result, peer review committees will face additional exposure to antitrust liability.

A. Applications

At first glance, after *Patrick,* lower courts may initially experience difficulty in applying the state action doctrine.[346] After holding that the state action doctrine may be an effective immunity, the Court did not go through a full *Midcal* analysis, but rather concentrated on the active supervision requirement. Furthermore, lower courts are forced to engage in too much statutory interpretation when applying the state action doctrine.[347] These interpretations may lead to conflicting decisions and confusion. Possible examples include *Marrese* and *Tambone,* both Seventh Circuit decisions.[348]

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than mere revenue figures such as receipt of insurance payments or purchasing of supplies from out of state sources. The court stated:

> [D]eterminations of [Sherman Act] jurisdiction [in hospital cases] are based not merely upon revenue figures, but on a broad aggregate of factors including proximity of the facility to regional centers of commerce or to other states, treatment of significant numbers of out-of-state patients, purchase of equipment and supplies from interstate sources and interstate transfer of payment for patient care.

Id.

342. Holthaus, *Peer Review After* Patrick *is Alive and Well,* HOSPITALS, Oct. 20, 1988, 34 (suggests that *Mitchell,* among other recent cases, offers hope for protection from antitrust liability for peer group members).

343. Patrick v. Burget, 486 U.S. 94, 99 (1988).

344. *Id.* at 101.

345. *Id.*

346. Lower courts seem to have no difficulty applying the principal set forth in *Patrick*. *See supra* notes 323-42 and accompanying text.

347. *See* Marrese v. Interqual, Inc., 748 F.2d 373 (7th Cir. 1984) (Seventh Circuit analyzed Indiana statutes to find state action); Patrick v. Burget, 800 F.2d 1498 (1986) (Ninth Circuit analyzed Oregon statutes to find state action), *rev'd,* 486 U.S. 94 (1988).

348. *See supra* notes 160-99 and accompanying text.

The Illinois and Indiana statutes in these decisions were very similar, but the Seventh Circuit reached opposite conclusions in each case.[349]

However, a closer examination of the *Patrick* decision reveals that lower courts really do have sufficient guidance in this area.[350] Regarding statutory schemes, lower courts have the Court's analysis of the Oregon statutes,[351] which ultimately proved to be insufficient in establishing immunity to physicians on peer review committees. To satisfy the state action doctrine, an activity must be clearly articulated as state policy.[352]

Also, to satisfy the state action doctrine active supervision by the state must exist. State officials must have and exercise control over any anticompetitive acts and have the power to disapprove of those that contradict state policy.[353] If lower courts engage in an accurate application of the *Midcal* test and follow the Court's reasoning in finding the Oregon statutes insufficient, conflicting decisions should not result. Furthermore, if the traditional antitrust cases suggested in *Patrick* are utilized when trying to apply the state action doctrine to peer review cases, statutory interpretation by lower courts should be straightforward and consistent.

B. Policy Considerations

Arguably, after *Patrick* the threat of liability may deter physicians from serving on committees or participating openly and honestly in peer review. In *Patrick,* the Court failed to address the public policy argument that subjecting peer review activities to antitrust liability would have an adverse effect on the quality of medical care.[354] Respondents argued that subjecting physicians to antitrust liability would prevent them from engaging openly and actively in peer review.[355] In response, the Court stated that an exploration of these policy arguments is best left to Congress.[356] The Court refused to address the broader public policy issues and stated that the activities of peer review committees would only be exempt if the state action doctrine is satisfied.[357]

In fact, Congress *has* addressed these policy considerations in the Health Care Quality Improvement Act.[358] With the Act, Congress intended to provide immunity to encourage participation on peer review committees, improve the quality of medical care, prevent malpractice, and prevent incompetent

349. *Id.*
350. *See supra* notes 237-58 and accompanying text.
351. *Patrick,* 486 U.S. at 102-03.
352. *Id.* at 100.
353. *Id.*
354. *Id.* at 105.
355. *Id.*
356. *Id.*
357. *Id.* at 105-06.
358. 42 U.S.C. §§ 11101-11152 (Supp. V 1987). *See supra* notes 77-83 and accompanying text.

physicians from moving freely from state to state.[359] The effect of the Act may neutralize the seemingly threatening holding of *Patrick* so that only egregious peer review behavior will be susceptible to attack. The impact that the Health Care Quality Improvement Act will have on this area is still unknown. Perhaps the Act is the solution to the many problems in this area.[360] When the Act becomes fully operational, state legislatures will not have to worry about drafting comprehensive statutes that immunize physicians on peer review committees. State courts will not have to analyze statutes to see if they satisfy the *Midcal* test. Instead, the courts would simply need to determine if the actions of a peer review committee met the standards set forth in section 11112 of the Act.[361] However, until courts have the opportunity to interpret the Act, the answers to these questions remain uncertain.[362]

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359. 42 U.S.C. § 11101(a)(1)-(4) (Supp. 1987). *See supra* notes 77-83 and accompanying text.

360. Several authorities have been critical of the Act. For example, one commentator has noted that the scope of the Act is very narrow. Also, the procedural and reporting requirements of the Act may be considered quite onerous. Finally, the Act "contains standards of 'reasonableness' that may allow a plaintiff to go to a jury to test the applicability of the Act alongside of the antitrust allegations." Cross & Berman, *supra* note 295, at 19. *See also* Proger, *Antitrust Developments Affecting the Health Care Sector,* 57 ANTITRUST L.J. 315, 319 (1988) The author states:

> The Act, however, is not a panacea for hospitals and their medical staffs wishing to escape federal antitrust challenges to their credentialing decisions. A plaintiff may obtain injunctive relief and attorneys fees; the Act does not apply to peer review actions involving allied health practitioners rather than physicians; the basis for the peer review decision must have been the physician's professional competence or conduct; and the initial determination of whether the damage immunity even applies can necessitate an extremely broad (and thus expensive) factual inquiry, which opens discovery to almost any question imaginable. Moreover, some of the Act's due process requirements necessary to ensure that immunity applies, go beyond protections required by some states and beyond those that result in efficient hospital proceeding.
>
> Compliance with the Act may necessitate amendment to medical staff bylaws, which always raises sensitive political issues. Perhaps the Act's greatest effect will be in providing a disincentive for plaintiffs and their attorneys to sue. In addition to providing damage immunity in appropriate circumstances, the court must award attorneys fees to defendants if the plaintiff's case was frivolous or brought in bad faith.

Id.

361. *See* Baker, *A Proposal for a Malice Barometer in Physician Peer Review: Twenty Questions You Should Ask,* 5 HOSPITAL LAW NEWSLETTER (1988) (suggesting method of assessing actions of peer review committee members for malice); George, *supra* note 78, at 401 (suggesting checklist to insure compliance with the Act).

362. In footnote 8, the Court stated that if physicians thought the Act provided them with insufficient immunity, they would have to take that matter up with Congress. *Patrick,* 486 U.S. at 105 n.8.

No immunity is given with respect to peer review involving nonphysicians. *See* George, *supra* note 78, at 401. No immunity is granted for actions seeking injunctive relief brought by the government or from actions alleging violations of civil rights law. *Id.* Also, a state may opt out of the Act by legislation. *Id.*

As to the actual chilling effect of the *Patrick* holding, studies have begun to show that physicians are aware of this decision and its effect on their willingness to participate in peer review is of varying degrees. For example, in a recent study by the Texas Medical Association on peer review practices, sixteen percent of responding physicians said that the possibility of a lawsuit makes them very reluctant to participate in peer review.[363] An additional fifty-one percent of the respondents were somewhat reluctant to participate.[364] Furthermore, fifty-seven percent of the physicians surveyed said they would be more likely to participate if they had legal immunity.[365]

If read carefully, however, *Patrick* will probably not have a chilling effect on peer review. The Court recognized the physicians on Columbia Hospital's peer review committee acted in bad faith.[366] The *Patrick* decision might have been very different if the clinic physicians had acted with integrity. *Patrick* sends the covert message to the medical community that only good faith peer review will be tolerated.[367] This is not to suggest that good faith review will always enjoy immunity from antitrust liability. However, good faith is one factor a court may look at in determining liability.[368]

Finally, once physicians realize that the Health Care Quality Improvement Act of 1986 is in effect, they may relax about the negative implications of the *Patrick* decision. To avoid liability for their actions, peer review committee members need only act in good faith. If they do so, they may be protected by state and federal immunity statutes. If they do not, they should face the consequences of their actions.

VII. CONCLUSION

After *Patrick,* it is clear that peer review committee activities may be the subject of federal antitrust claims. Moreover, although the state action

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363. Ross, *Peer Review in Texas—A Survey of Medical Staffs,* 83 TEX. MED. 91, 92 (Mar. 1987).

364. *Id.*

365. *Id.*

366. *Patrick,* 486 U.S. at 98 n.3. The Court stated that the Ninth Circuit had found the respondents' conduct to be "shabby, unprincipled, and unprofessional." *Id.*

367. In September of 1988, five physicians at Children's Memorial Hospital in Chicago, Illinois were surveyed regarding the *Patrick* decision. Those surveyed included Dr. Margaret O'Flynn M.D., Chief of Staff, Dr. John Raffensperger M.D., Chief of Surgery, Dr. G.W. Stevenson M.D., anesthesiologist, Dr. Steven Hall M.D., anesthesiologist, and Dr. Lauren Holinger M.D., Division Head of Ear, Nose, & Throat Department. Every physician had heard of the *Patrick* decision. No physician seemed concerned that his or her peer review group involvement would subject him or her to antitrust liability. At least two physicians stated that *Patrick* simply meant they should act in good faith. Survey by Susan Capra, Children's Memorial Hospital, Chicago, Illinois (Sept. 1988).

368. Koska, *Proper Procedures Are Key to Peer Review Legality Experts Say,* HOSPITALS, June 20, 1988, at 65. The author recommends that physicians engaging in peer review may limit their legal risk to antitrust liability if they avoid bad faith and follow sound hospital bylaws. *Id.*

doctrine may continue to offer immunity to peer review committees, this is true only if the *Midcal* test has been satisfied. *Patrick* has made the *Midcal* test more difficult to pass. However, the Health Care Quality Improvement Act of 1986 may provide additional protections which negate the effects of *Patrick*. With the various immunity statutes, physicians may not be chilled from participation on these important committees. However, *Patrick* tells the medical community that only good faith reviews are acceptable.

The *Patrick* decision changes little; it merely defines a stricter standard for antitrust immunity under the state action doctrine. Health care professionals may be understandably concerned. However, as the medical profession continues to take on the characteristics of big business, perhaps it should also assume the responsibilities. One of those responsibilities is to comply with the federal antitrust laws. The ultimate impact of this decision is to encourage good faith peer review decisions. This result can only benefit all involved.

Susan Capra